

Rocky Mountain Medical Journal



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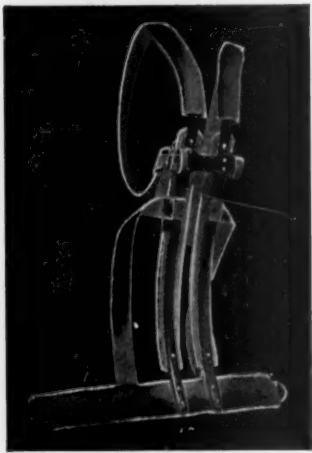
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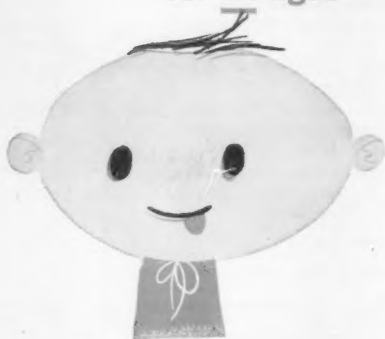
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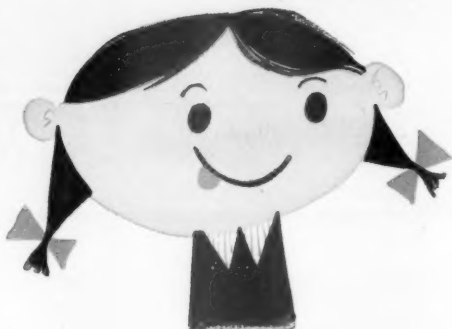
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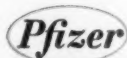
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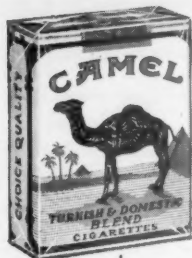
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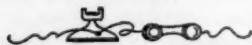
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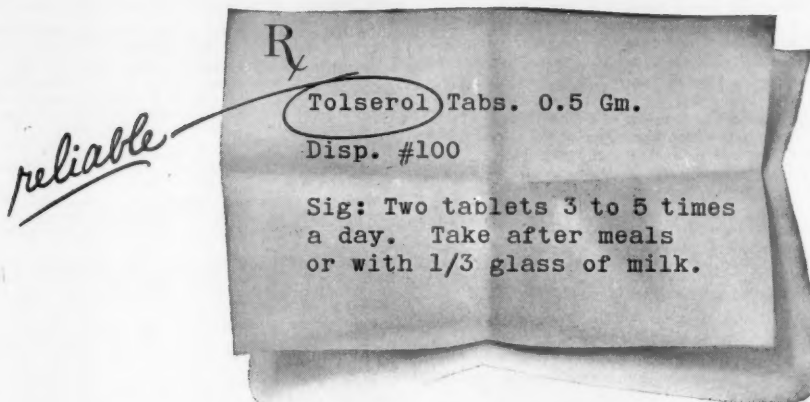
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The Upjohn Company, Kalamazoo, Michigan



THE WYOMING STATE MEDICAL SOCIETY

NEXT ANNUAL SESSION: SHERIDAN, JUNE 7, 8, AND 9, 1954

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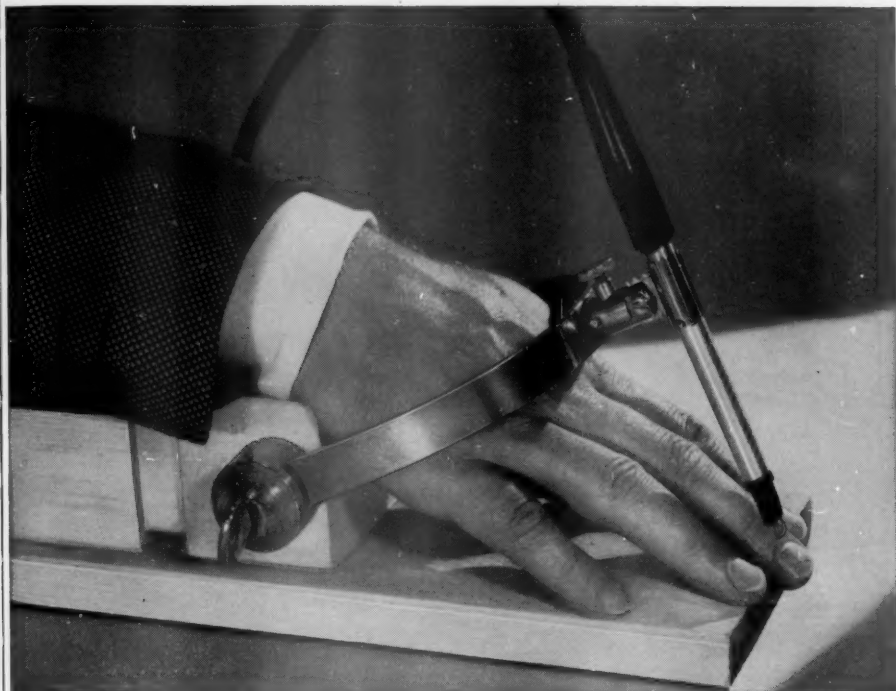
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Physiological test compares **Kent's** "Micronite" Filter with other cigarette filters



To compare the efficiency of various filters as they affect physiological responses in the cigarette smoker, drop in surface skin temperature at the last phalanx was measured.

Using well-established procedures, the subject smoked conventional filter cigarettes and the new KENT with the exclusive "Micronite" Filter.

For every other filter cigarette, the drop in temperature averaged over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

These findings confirm the results of other scientific measurements that show these facts: ordinary cotton, cellulose or crepe paper filters remove a small but ineffective amount of nicotine and tars; KENT's Micronite Filter

approaches 7 times the efficiency of other filters in the removal of nicotine and tars and is virtually twice as effective as the next most efficient cigarette filter.

Thus KENT, with the first filter that really works, gives the one smoker out of every three who is susceptible to nicotine and tars the protection he needs . . . while offering the satisfaction he expects of fine tobacco.

For these reasons, smokers have made the new KENT the most popular new brand of cigarette to be introduced in the last 20 years.

If you have yet to try the new KENT, may we suggest you do so soon?

Takes out up to 7 times more nicotine and tars than other filter cigarettes



They all like A



ke pediatric

ERYTHROCIN

TRADE MARK

STEARATE

(Erythromycin Stearate, Abbott)

oral suspension

... the cocci-killing antibiotic for children of all ages. Tasty, stable, ready for instant use. *No mixing required*—drug retains potency for at least 18 months.

Winter infections—otitis media, bronchitis, sinusitis, pharyngitis and pneumonia—are especially sensitive to *Pediatric* ERYTHROCIN. Also, pyoderma, erysipelas, certain cases of osteomyelitis, and other infectious conditions.

Many physicians make it a practice to always prescribe *Pediatric* ERYTHROCIN when the organism is staphylococcus, because of the high incidence of staphylococcal resistance to many other antibiotics. And when the organism is resistant or when the patient is sensitive to penicillin and other antibiotics.

Pediatric ERYTHROCIN is specific in action—*less likely to alter normal intestinal flora than most other antibiotics*. Gastrointestinal disturbances are rare. No serious side effects reported.

Pediatric ERYTHROCIN can be administered before, after or with meals. Available in 2-fluidounce, pour-lip bottles.

Your little patients will like *Pediatric* ERYTHROCIN. **Abbott**

1-291

DOSAGE

One 5-cc. teaspoonful
represents

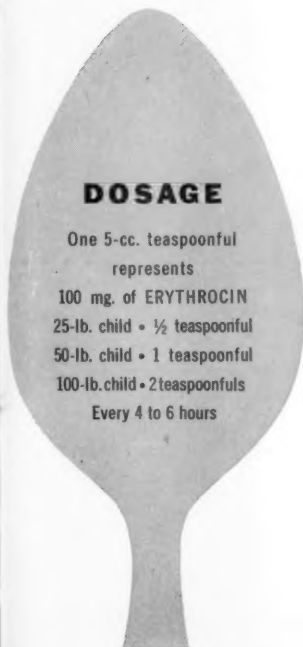
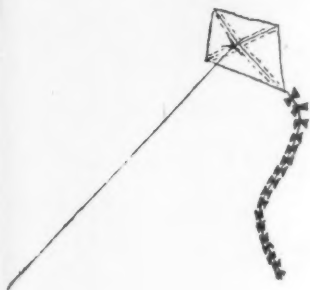
100 mg. of ERYTHROCIN

25-lb. child • $\frac{1}{2}$ teaspoonful

50-lb. child • 1 teaspoonful

100-lb. child • 2 teaspoonfuls

Every 4 to 6 hours



Conclusive evidence

of the effectiveness and low toxicity

of Furadantin

in treating bacterial urinary tract infections

is provided in its recent

acceptance by the Council



.....**FURADANTIN**[®].....
brand of nitrofurantoin



The N.N.R.
monograph
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EATON Inc.
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Nitrofurantoin.—Furadantin (Eaton).—

Actions and Uses.—Nitrofurantoin, a nitrofuran derivative, exhibits a wide spectrum of antibacterial activity against both gram-positive and gram-negative micro-organisms. It is bacteriostatic and may be bactericidal to the majority of strains of *Escherichia coli*, *Micrococcus* (*Staphylococcus*) *pyogenes* *albus* and *aureus*, *Streptococcus pyogenes*, *Aerobacter aerogenes*, and *Paracolobactrum* species. The drug is less effective against *Proteus vulgaris*, *Pseudomonas aeruginosa*, *Alcaligenes faecalis*, and *Corynebacterium* species; many strains of these organisms may be resistant to it. However, bacterial resistance to other anti-infective agents is not usually accompanied by increase in resistance of the organisms to nitrofurantoin. The drug does not inhibit fungi or viruses.

Nitrofurantoin is useful by oral administration for the treatment of bacterial infections of the urinary tract and is indicated in pyelonephritis, pyelitis, and cystitis caused by bacteria sensitive to the drug. It is not intended to replace surgery when mechanical obstruction or stasis is present. Following oral administration, approximately 40% is excreted unchanged in the urine. The remainder is apparently catabolized by various body tissues into inactive, brownish compounds that may tint the urine. Only negligible amounts of the drug are recovered from the feces. Urinary excretion is sufficiently rapid to require administration of the drug at four to six hour intervals to maintain antibacterial concentration. The low oral dosage necessary to maintain an effective urinary concentration is not associated with detectable blood levels. The high solubility of nitrofurantoin, even in acid urine, and the low dosage required diminish the likelihood of crystalluria.

Nitrofurantoin has a low toxicity. With oral administration it occasionally produces nausea and emesis; however, these reactions may be obviated by slight reduction in dosage. An occasional case of sensitization has been noted, consisting of a diffuse erythematous maculopapular eruption of the skin. This has been readily controlled by discontinuing administration of the drug. Animal studies, using large doses administered over a prolonged period, have revealed a decrease in the maturation of spermatozoa, but this effect is reversible following discontinuance of the drug. Until more is known concerning its long-term effects, blood cell studies should be made during therapy. Frequent or prolonged treatment is not advised until the drug has received more widespread study. It is otherwise contraindicated in the presence of anuria, oliguria, or severe renal damage.

Dosage.—Nitrofurantoin is administered orally in an average total daily dosage of 5 to 8 mg. per kilogram (2.2 to 3.6 mg. per pound) of body weight. One-fourth of this amount is administered four times daily—with each meal and with food at bedtime to prevent or minimize nausea. For refractory infections such as *Proteus* and *Pseudomonas* species, total daily dosage may be increased to a maximum of 10 mg. per kilogram (4.5 mg. per pound) of body weight. If nausea is severe, the dosage may be reduced. Medication should be continued for at least three days after sterility of the urine is achieved.

'Carbo-Resin' Therapy Simplifies Control of Edema

- Permits more liberal salt intake, enhances palatability of diet
- Safely removes sodium from intestinal tract and prevents its reabsorption
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- May be lifesaving therapy for patients who have developed a resistance to mercury
- Useful in congestive heart failure, cirrhosis of the liver, edema of pregnancy, hypertension, or whenever salt restriction is advisable

*Eli Lilly and Company
Indianapolis 6, Indiana, U. S. A.*



*Suspended in
orange juice*



*Baked into brownies
or cookies*



*Blended into
gelatin dessert*



Variety is the key to palatable 'Carbo-Resin' therapy.

'Carbo-Resin,' Unflavored, may be incorporated into cookies, fruit juices, and desserts. Printed recipes for your patients are available from the Lilly representative or direct from Indianapolis. A book containing low-sodium diets is also available for distribution to patients.

CAUTION: 'Carbo-Resin' is supplied in two forms—flavored and unflavored. Only 'Carbo-Resin,' Unflavored, is suitable for incorporation into recipes.

POWDER
'Carbo-Resin'

(CARBACRYLAMINE RESINS, LILLY)

Rocky Mountain

Colorado
Montana
New Mexico
Utah
Wyoming

DECEMBER
1953

Medical Journal

Editorial

Thanks for A Good Move

OUR appreciation to the Continental Casualty Company of Chicago, which has just announced transfer of all its rights to the name "Blue Seal" to the Blue Shield Medical Care Plans through the national Blue Shield Commission!

For years the public has been confused and physicians have been irritated by widespread imitation, just as closely as copy-right and trade-mark laws would permit, of the titles of Blue Shield and Blue Cross plans. Aside from the American Red Cross which almost everyone knows about, we have seen "crosses" and "shields" of many colors, and Blue This and Blue That, until people have no real idea which is which among voluntary medical and hospital insurance plans.

Blue Cross was sponsored by hospitals as a voluntary non-profit hospital insurance plan and Blue Shield was fathered by the medical profession as a voluntary non-profit medical and surgical insurance plan. They were and are sound, honest, public-service endeavors, designed to ease the admittedly high costs of modern health care. Their success has inspired many insurance companies, most of them equally honest and sound, to enter the same field for both profit and public service. It is the fastest growing field of insurance in world history.

When dealing with groups of selected risks, commercial insurance companies can sometimes offer more coverage for less premium than can Blue Cross and Blue Shield. This is fine. Competition in this whole field is fine, so long as it is honest and fair. Competition keeps everyone on his toes to give increasingly better service to the people, and it is the American Way. But

if competition is to be fair, it brooks no imitative names or play upon the words in competitors' titles.

What other insurance company will be next to decide that it can proceed on its own feet instead of trying to ride the coat-tails of Blue Cross and Blue Shield?

• • •

An Editor Makes A Diagnosis

MR. PALMER HOYT, editor and publisher of The Denver Post, was principal speaker at the banquet of the Eighty-third Annual Session of the Colorado State Medical Society in Denver on October 2. Many colleagues from these Rocky Mountain States were present and Mr. Hoyt's address was of national, as well as regional, interest. He discussed the rise of medicine, parallel in its progress to that of the human race. Both have sought freedom, and each is in danger of losing it while somehow losing sight of the main objective. Physicians themselves are the key in the fight to forestall socialized medicine which, if it gets in, dooms our country to socialism. Many of us do not realize that the first proposal for socialized medicine on a national scale was during the presidency of Calvin Coolidge. More serious proposals were made in 1932, but we were not under heavy fire until the years of the second world war. The threat came to a head in 1948 when Federal Security Administrator Oscar Ewing handed Truman a call for national health insurance. Though it was defeated, the back door is still open. A large per cent of the people get government subsidized medical service from forty-six agencies. The Veterans Administration is the biggest government venture in the field, serving about 20,000,000 persons

—and the number is increasing at the rate of about one million per year.

We can waylay its advent by expanding medical education and voluntary health insurance. If the majority of voters get the idea they can procure more and better medical care from the government for less cost, we'd better look out! We must avoid overcharging, and patients' pocketbooks must be respected along with their problems of health. Our profession needs a greater voice in the way many health insurance companies write their policies and fulfill obligations to their clients.

Many people in Great Britain could never in the past afford adequate medical and dental service; thus, to them socialized medicine is not the failure that thousands of Americans believe it to be. The British have become used to queuing up for their wordly goods through two world wars. Production-line medical service fits more into their habits than into ours, and it will behoove us to avoid it. Americans are busy and their time, as well as pocketbooks, must be respected. Those of us who habitually make them wait unreasonable periods of time are asking for loss of their loyalty at the polls—a fellow can get that kind of service for less money, as in England, he thinks.

Mr. Hoyt described public relations as the art of getting along with people, of inspiring them to believe we are what we ought to be. Hundreds of thousands of American citizens are unaware of what our profession has done for their health and life expectancy, how we and our institutions are making life worth living—and the best we have to offer is available to all, one way or another, regardless of ability to pay. Free and part-pay clinics are still freely manned by our profession; few indeed are the physicians who do not give hundreds or thousands of dollars' worth annually without material reward. People should know more of these facts, but newspapers have difficulty in getting factual, especially encouraging, information from us.

Malpractice suits are increasing, partly due to the fact that insurance carriers can usually pay off a threat as a "nuisance case"

cheaper than they can defend the physician in court. We should go to court when we are innocent, win the case and publicize it! Better, however, would be the practice of more preventive law along with our medicine. Pre-operative explanations, guarded prognostications, and simple discussion of probable and possible results would avoid misunderstandings which beget legal complications. Our side should be as clear as the patients'. This is true socially, politically and financially, as well as professionally. We should assume an increased share of the work and progress in general public affairs, sharing thereby the non-medical problems of our patrons.

Directory Postponed From February to May

YOUR Journal management has been authorized by its Board of Trustees to postpone publication of the Annual Directory of Members of our five Rocky Mountain state medical societies from February, 1954, to May, 1954.

The postponement was decided upon because of announcements by the Mountain States Telephone and Telegraph Company of large-scale changes to be made in telephone numbers throughout this region effective next May. Many telephone exchanges covering whole towns and cities will be converted from the old-style manual type to dial exchanges, with consequent mass changes of telephone numbers. Others already on the dial system, including the entire city of Denver, will be mass-converted to the new seven-digit number system, to conform to the developing national system for intercity dialing of toll calls.

If our Directory were issued as usual next February, almost half of its telephone numbers would be useless before the Directory was three months old.

All members in our five-state area will receive the usual Directory Information Cards to bring their personal listings up to date, but they will be mailed in March, 1954, whereas under the older plan they would have reached members in late November.

Original Articles

TEAMWORK IN CEREBRAL PALSY*

PAUL A. DRAPER, M.D.
COLORADO SPRINGS

With increasing reports in both the medical and lay literature concerning cerebral palsy, it behooves the internist to reassess this condition. The term, "Cerebral Palsy," is popularly used to designate a group of neuromuscular disabilities in which muscular control is impaired, modified or lost, depending on the type and degree of various kinds of pathological involvement of several different motor centers of the brain. Because of the pluralism of the condition, a better over-all term might be "Cerebral Palsies." The word "cerebral" distinguishes these paralyzes from those of spinal or peripheral origin.

In the United States alone, more than a half million persons are known to have had cerebral palsy since birth or early childhood, and there are probably many of whom we have no record. In Colorado, it is estimated that we have 5,000 such individuals, about ninety in El Paso County alone. Of the general crippled children's case load, poliomyelitis constitutes 14 per cent and cerebral palsy 13 per cent. While polio runs in cycles of epidemics, the C.P. rate is constant and averages the same over a ten-year period. Also, thousands of adults have developed cerebral palsy through head injuries, encephalitis, tumors or cerebral hemorrhage. It is thus evident that cerebral palsy, which is generally an incapacitating rather than a killing disease, offers the medical profession a great challenge.

Present-day classification includes five general groups of cerebral palsy: (1) spastic paralysis, (2) athetosis, (3) ataxia, (4) rigidity and (5) those with tremors. About 40 per cent have the spastic type, 45 per cent are athetoid and the remaining 15 per cent are those with ataxia, rigidity and tremors. Occasionally mixed types occur,

especially the rigidity-tremor combination which is seen in patients who have had brain infections like encephalitis; this is an acquired type of cerebral palsy. The old name "spastic paralysis" derives from Dr. W. J. Little of London, for whom this disorder was originally called "Little's Disease" in 1861. It must be noted, however, that the so-called "spastics" constitute less than 50 per cent of the total group of the cerebral palsied.

About one-third of the entire group of cerebral palsied children have been found to be uneducable by reason of mental deficiency. This figure is much lower than was originally realized. Many cerebral palsied children have been incorrectly classified as mentally retarded because of their facial grimaces, drooling, lack of coordinated speech and other conditions often seen in the imbecile. Two-thirds of these children, however, have I.Q.'s of 70 or higher and more than half of them are of normal or superior intelligence, have the personality characteristics of non-handicapped children, and are unquestionably teachable.

Defective speech and visual and auditory loss are often present along with the motor handicaps. These should all be taken into consideration in the determination of educability. Convulsive disorders also complicate certain cases.

Etiological factors are conveniently listed according to their prenatal (30 per cent), natal (60 per cent), or postnatal (10 per cent) occurrence. In the past it was felt that most cerebral palsy was the result of birth injury, and obstetricians received most of the blame. It is, of course, known that some babies are injured at birth, and that some cerebral palsy is caused by trauma to the head at birth, with subarachnoid hemorrhage and brain softening. Statistics, however, reveal that there is no difference

*Presented at the regional meeting of the American College of Physicians, Denver, February 17, 1953.

whether the children are born in the finest obstetrical hospitals or delivered by midwives in isolated districts. In reality, not more than 5 per cent of all cerebral palsy cases are due to any form of birth trauma. It seems certain that cerebral palsy is, in some cases, the result of variations in the developmental structure of the brain. As to what is back of extremes in these variations, we do not as yet have all the answers. Kernicterus, due to the Rh factor, has been blamed in about 10 per cent of the cases. With transfusions and public education, this figure has now been reduced to 3 per cent. Very few correlations have been established between cerebral palsy and the background conditions of those afflicted. The best available data at present indicate that the condition is more common among whites than Negroes, among the first-born than the later-born, and among males than females. Cerebral palsy is very rarely hereditary.

A complete diagnostic screening process is essential in order that those who are capable of rehabilitation and training may be helped by the limited facilities now available. The initial examinations should, as a minimum, consist of pediatric, neurologic and orthopedic evaluations, and very frequently speech, visual and auditory tests should be made. In addition, consultation by an orthodontist or a laryngologist will sometimes be helpful. Electroencephalograms have proved helpful in localizing cerebral abnormality. Psychometric studies and psychologic appraisals help to determine educability and a long-range planning and prognosis. In fairness to all, however, it should be stated that the measuring of intelligence of some children with cerebral palsy is a most difficult matter. Even the existing standard intelligence tests are not always satisfactory for these patients. Because most of such children have been handicapped since birth or shortly thereafter, they have not had a chance to develop the speech and reading abilities, or the motor skills, upon which most intelligence tests depend. Nevertheless, some new tests are being developed which are proving of special value in approaching the correct I.Q. of the individual cerebral palsied child.

The lesson for physicians to remember is

that some individuals who show certain manifestations of an imbecile are not in that intelligence classification at all and do have salvage value. Recently, we have started using the Leiter Scale, developed by Dr. Gwen Arnold of the University of Wisconsin. With this test the only response required is a nod or shake of the head or other signal for "Yes" or "No." The test material is novel, the scoring is completely objective, and the test has a high index of reliability. For children whose speech is relatively intelligible, the Children's Apperception Test is useful for the psychological exploration of the C.P. child's emotional condition. This is a highly important part of any examination and should always be secured before any kind of therapy is begun. The Vineland Social Maturity Scale by Edgar Doll is useful in assessing the child's social maturity, the things he can do for himself, etc. It yields a "social quotient" which is comparable in methodology to the determination of the I.Q.

Following the initial medical screening and diagnostic classification, comes the long-range program of treatment, training and education. This is a field where existing facilities and personnel are far from adequate. At present, there are facilities for only 10 per cent of the cerebral palsied to obtain treatment. One reason why this field has been so long neglected and poorly staffed is that its limits are so wide and its problems so varied. Different specialty groups have shown some isolated interest, but so far there has been little coordinated effort or combined clinic activity. Another reason is the persistence in the literature, both medical and non-medical, of the impression that cerebral palsied patients are generally feeble-minded or so limited in their speech or motor functions that little is to be gained by treatment or training. Insufficiency of therapeutic efforts has also stemmed from the fact that attention has been concentrated mainly on orthopedic involvement. A comprehensive habilitation program must utilize the talents of many whose work is concerned with all the varied aspects of the development of the child. With this approach in a few places, some very worthwhile results are being achieved.

Cerebral palsied adults are being helped, too. It must be emphasized, however, that habits of walking and speech that have been established for many years are much more difficult to change or eliminate.

Any treatment set-up for cerebral palsy should include a qualified physical therapist. There are two essential parts of the physical therapy program: (1) specific muscle education, including exercises for increasing muscle strength, developing fundamental motor patterns such as leg reciprocation, reach and grasp, improving coordination and control and technics for training in conscious relaxation; (2) training for normal activities such as balance and reciprocation by the use of braces and special apparatus.

The value of speech training cannot be overemphasized. Approximately 75 per cent of all children with cerebral palsy have speech defects. From 50 to 75 per cent of these can be benefited by expert speech training. Giving the child a chance to express himself helps him to acquire a more pleasing personality, stimulates mental growth and improves his chance of becoming self-supporting. Desirable ancillary equipment includes a tape-disc recording machine. It facilitates objective study of the progress of the patient at various stages of training; it aids parents to continue the child's speech training at home; it gives encouragement to the student-patient and serves as a projective test to help expose a child's emotional problems.

Occupational therapy is a valuable adjunct. It encourages finer manipulative movements of the hands and fingers; it stimulates attention, perception, patience and self-discipline; it fosters independence, sociability and creativity, and it helps to relieve tension by giving opportunity for receiving approval, approbation and recognition.

With reference to physicians on the training staff, the pediatrician cares for new physical ailments as they arise, the neurologist checks for changes in muscle tone and severity of involvement, a neurosurgeon is occasionally required to remove focal brain lesions, the otologist prescribes hearing aids, lip-reading instruction, or both. An oculist

is needed, not only for correction of refractive error but to supervise squint treatment since strabismus is present in about one-fourth of cerebral palsied children. A psychiatrist is not infrequently needed to handle the emotional problems. In this connection, I have found it helpful to hold group counseling sessions with parents. Their emotional interplay with their cerebral palsied child has a potent influence on the child's ability to respond to the other therapies. The dentist is sometimes of definite help, not just for routine care of the teeth but more particularly for straightening them, eliminating malocclusions, and thus providing for better articulation.

We are greatly indebted to orthopedic surgery for much of what has been accomplished thus far in cerebral palsy. Modern orthopedists, however, are usually the first to stress that surgery is only one part of a broad plan of treatment for this condition, and that surgery is not a substitute for other habilitative measures. Surgery will always have its place in the treatment of cerebral palsy, and with increasing study regarding technics and applicability will likely assume increasing value in special instances.

Several drugs have been rather widely used in cerebral palsy, but they appear to have only limited value. Neostigmine, both by mouth and intramuscular injection, is one of the drugs most frequently employed. Both favorable and unfavorable reports have been made. It seems likely that this drug may produce temporary relief in atonic spastic diplegia, whereas it may augment the muscle tonus of some of the dyskinesias. Anti-convulsive drugs have their specific indications, and phenobarbital seems to be most effective in children. Tridione has been of a little help, but more in spinal than in cerebral spastic conditions, and photophobia and hemeralopia were encountered in half the cases tested. Both Artane and Tolserol have been disappointing, as there was no diminution of the stretch reflex or in improving functions of normal living. Tubocurarine in peanut oil and myricin has been found to be of considerable symptomatic value in postoperative care of spastic patients, resulting in less pain and a less stormy postoperative course. Better im-

mobilization has resulted for postoperative athetoid patients. Also, diminution in spasticity has permitted facilitation of training and corrective procedures.

For the future, there is need not only for betterment of the some fifty cerebral palsy training centers and clinics in the United States but for many more such places, properly equipped and staffed with trained personnel. Surveys and publicity are being conducted to locate cerebral palsied persons whose condition has remained unidentified or untreated. Research is being carried on in twenty universities and hospitals.

Finances for this work have been furnished mostly by private contributions. Several centers are state-sponsored. Rare is the family which can afford anything approaching the full amount needed for continued care of these chronically handicapped individuals.

There is developing a quickening of interest regarding special attention to modified educational procedures and vocational training for the cerebral palsied. Combined hospital-school facilities are desirable for one-sixth of these children. Denver has a special school nearing completion.

The entire cerebral palsy program in the United States is being spearheaded by the United Cerebral Palsy Association and its various state and local subsidiaries. Also, the National Society for Crippled Children and Adults has long been interested in this problem. Cerebral palsy treatments are given at Sewell House and at Children's Hospital in Denver. Greeley has a Pre-school. Colorado Springs has had a cerebral palsy training center since September, 1949. It was initially financed by the local Elk's Club, and is now being supported by various community groups, along with U.C.P.A. We have access to all the medical specialties and are attempting to obtain space for in-patient service and for a special school room. A new C.P. Center is now nearing completion in Denver. It gives promise to being one of the finest of its type and will handle all phases of the cerebral palsy problem. Professional stimulation has been afforded by the American Academy of Cerebral Palsy. Besides scientific meetings of its members, it sponsors courses in designated centers for

those who desire specialized training. Some of the younger members of the profession are accepting the opportunity of postgraduate medical training in this new and extensive field.

While the emergence of both professional and public leadership in cerebral palsy is encouraging, much still needs to be done. As more knowledge is gained in this new field of medicine, it will require even better integrated teamwork of all concerned to administer this new knowledge in meeting all of the needs of those with cerebral palsy.

The Book Corner

New Books Received

Introduction to Laboratory Chemistry: By L. Earle Arnow, Ph.G., B.S., Ph.D., M.D., M.B., Director of Research, Sharp & Dohme Division, Merck & Co., Inc.; Professor of Chemistry, Bryn Mawr College Summer School of Nursing. Revised with the assistance of Marie C. D'Andrea, R.N., B.S. in Nursing Education, Educational Director, School of Nursing, St. Vincent's Hospital, Indianapolis. The C. V. Mosby Company, St. Louis, 1953. Price, \$1.50.

Introduction to Physiological and Pathological Chemistry: By L. Earle Arnow, Ph.G., B.S., Ph.D., M.D., M.B., author of Introduction to Laboratory Chemistry. Revised with the assistance of Marie C. D'Andrea, R.N., B.S. in Nursing Education; fourth edition. The C. V. Mosby Company, St. Louis, 1953. Price, \$3.75.

Antibiotics: By Robertson Pratt, Ph.D., Professor of Pharmacognosy and Plant Physiology, University of California College of Pharmacy; Consultant on Antibiotics. And Jean Dufrenoy, D.Sci. (Paris), Research Associate in Antibiotics, University of California College of Pharmacy; 87 illustrations, including one plate in full color; second edition. J. B. Lippincott Co., Philadelphia, London, Montreal. Price, \$7.50.

Surgery of the Biliary Tract, Pancreas and Spleen, A Handbook of Operative Surgery: By Charles B. Puestow, M.D., Ph.D. (Surg.), Clinical Professor of Surgery, College of Medicine and Graduate College, University of Illinois; Attending Surgeon, University of Illinois Research and Educational Hospitals; Chief Surgeon, Henrotin Hospital, Chicago. Illustrated by Jessie W. Phillips. The Year Book Publishers, Inc., 200 East Illinois Street, Chicago, Ill. Price, \$9.00.

Disability Evaluation, Principles of Treatment of Compensable Injuries: By Earl D. McBride, B.S., M.D., F.A.C.S., Assistant Professor in Orthopedic Surgery, University of Oklahoma School of Medicine; Attending Orthopedic Surgeon to St. Anthony's Hospital. J. B. Lippincott Company, Philadelphia, London, Montreal.

The Anatomy and Surgery of Hernia: By Leo M. Zimmerman, M.D., Professor of Surgery and Co-Chairman of the Department of Surgery, Chicago Medical School; Attending Surgeon, Michael Reese, Cook County and Chicago Memorial Hospitals. And Barry J. Anson, Ph.D. (Med. S.C.), Professor of Anatomy, Northwestern University Medical School; Member of Attending Staff Passavant Memorial Hospital. The Williams & Wilkins Company, Baltimore, 1953. Price, \$10.00.

Cure Your Nerves Yourself. A famous psychiatrist tells you how to help yourself over the emotional maladjustments you can recognize and cure without expensive professional help. Louis E. Bisch, M.D., Ph.D. Copyright, 1953, by Wilfred Funk, Inc. Printed in the United States of America, Library of Congress Catalog Card No. 53-10384. Price, \$3.50.

RESPIRATORY PROBLEMS IN ACUTE BULBAR POLIOMYELITIS*

ROBERT S. ELY, M.D.
SALT LAKE CITY, UTAH

The importance of respiratory complications in the patient with acute bulbar poliomyelitis has begun to receive emphasis only recently. First recognition was centered about inadequate inspiration occurring during the acute illness in certain of these patients and of oxygen deprivation that resulted. In an effort to correct this, oxygen by tent, mask, catheter and tracheotomy tube has been employed with increasing frequency. In addition, it is known that there is also a vital need for the patient to expire air adequately, otherwise carbon dioxide produced by the body would accumulate excessively and create the physiologic disturbance, respiratory acidosis. Therefore, as respiratory complications may lead to inadequate respirations of either or both inspiration and expiration, signs of both must be watched for in the individual patient.

Respiratory complications frequently begin early in the course of bulbar poliomyelitis. In the child, bulbar symptoms usually have developed insidiously enough so that one to three days may progress before hospitalization. Often during this time oral fluid administration has been attempted. Aspiration of this fluid or of accumulating pharyngeal secretions may well result in some obstruction of the respiratory tree. If the total fluid intake is poor, secretions tend to be thick and tenacious and hence cause a greater problem of respiratory obstruction. It can be seen that the dangers of respiratory complications in patients with bulbar poliomyelitis arise with first symptoms of the illness. Frequency of respiratory complications in acute bulbar poliomyelitis, particularly in the fatal cases, and frequency of respiratory acidosis in the bulbar group has prompted a discussion of the problems which arose in those cases seen at the Salt Lake General Hospital in 1951.

*From the Department of Pediatrics, University of Utah College of Medicine, Salt Lake City, Utah.

Patient Observations

During the 1951 epidemic of poliomyelitis in Utah, 153 children with this diagnosis were admitted to the Isolation Ward of the Salt Lake General Hospital. Diagnosis of bulbar poliomyelitis was made in fifty-eight (38 per cent) of these. Thirteen patients (22 per cent) of this latter group expired of their disease; the high incidence of bulbar poliomyelitis cases and of their fatality is the result of an exceptional patient selection, for throughout the period of this epidemic an attempt was made to admit only the more ill patients to this hospital.

During this period the medical staff became increasingly aware of the frequency and importance of respiratory complications in these children. These complications, consisting of aspiration of secretions pooled in the pharynx or plugging of bronchi and bronchioles by thick mucous secretions, would frequently occur in patients whose oxygenation remained adequate by clinical and oximetric evaluation. In these patients a state of respiratory acidosis would exist consisting of a low blood pH and a high bicarbonate concentration. Associated with acidosis a restlessness, confusion, or marked depression sometimes was present; in two or three patients this seemed to be related to the degree of CO₂ accumulation.

Two patients serve as illustrations of this respiratory acidosis: The first of these demonstrates how inadequate respiration from slowly progressing paralysis causes CO₂ to accumulate and how it may be corrected when pulmonary obstruction is not present. (See Fig. 1).

CASE 1

E.S., a boy 12 years of age, was admitted to the hospital on August 16, 1951. Four days prior to admission he had the symptoms of fatigue, headache, and stiffness of the neck. The next day he could not swallow well, had slurred speech and a nasal tone of voice. He vomited on one occasion on this day. These symptoms continued until the day of admission when he "strangled" on medications and was referred to the hospital. On examination at the time of

admission there was pooling of secretions in the pharynx with nasal regurgitation when he attempted to swallow. There was slight weakness of the intercostal muscles bilaterally. He was placed in an oxygen head tent in Trendelenburg position and his pharynx was aspirated frequently. At the time sample No. 1 was drawn he seemed to be respiring adequately. A tracheotomy was done later this same day to provide a clear route of respiration and oxygen was given through the tracheotomy canula.

Sample No. 2 was obtained the morning of August 17, 1951, when, although the patient was restless, febrile and anxious, he was still suctioning himself and still seemed to be ventilating well. Later that afternoon he became more restless, was resistive and had shallow respirations. He then developed an increase in pulse rate, a drop in blood pressure and became comatose. Sample No. 3 was taken at this time. He was then placed in a respirator. Over the next several hours he remained comatose and about three hours after sample No. 4 was obtained, he became progressively more cyanotic and expired.

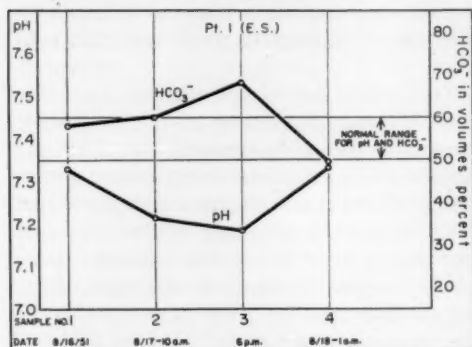


Fig. 1. Course of Respiratory Acidosis in Patient No. 1.—E.S.

In Fig. 1 it can be seen that the values for pH and bicarbonate (in volumes per cent) were essentially normal at the time the first sample was obtained. Sample No. 2, taken when the patient apparently had adequate respirations clinically, indicates the beginning of respiratory acidosis evidenced by the fall in pH and slight rise in the HCO₃ concentration. In sample No. 3 the respiratory acidosis had increased by virtue of continued CO₂ accumulation which further lowered the pH and raised the HCO₃ concentration. At this time inadequate respirations were apparent clinically and sample No. 4 shows how the respirator served to provide adequate respirations and hence to remove the excess CO₂ accumulated. Unfortunately, more vital centers became involved and he succumbed soon thereafter.

The second patient illustrates how the

combined circumstances of pulmonary obstruction and poor motor control of respirations may cause an accentuation of respiratory acidosis. In such an instance CO₂ may accumulate to markedly abnormal levels and fail to return to normal after the use of a respirator and/or bronchoscopy. This indicates the presence of atelectasis, pneumonia or pulmonary edema even when these complications are not recognized clinically. It should be mentioned that oximeter studies in this patient indicated adequate oxygenation until terminally.

CASE 2

R.K.J., aged 8, developed fever and a sore throat three days before admission. The day before admission he had a "tired" throat. That day and the day of admission he regurgitated fluid and medications through his nose several times. On examination he had moderate stiffness of the neck, pharyngeal paralysis and pooled secretions in the pharynx. Innervation of the respiratory muscles was apparently intact.

Although acutely and severely ill, the patient was conscious and was able to aspirate his pharynx himself initially. He was placed on parenteral fluids, put in Trendelenburg position and given oxygen therapy in a head tent. The day after admission he aspirated some pharyngeal secretions, following which tracheotomy was performed. Consciousness remained nearly intact for the first three days of hospital care and the patient appeared adequately oxygenated. However, following the return of temperature to normal, ordinarily a correlate of recovery, he gradually became increasingly comatose. At this time he was placed in a respirator. Although oximeter recordings and clinical evaluation indicated an adequate oxygenation, his bicarbonate levels in the blood increased progressively and the pH decreased (shown in Fig. 2), indicating respiratory acidosis (samples No. 5-7). Since he was already in a respirator and should otherwise have been able to "blow off" his retained CO₂, the clinical inference was that a pulmonary obstruction existed. Careful physical check of the patient suggested atelectasis of the left side at this time (sample No. 7), but a chest roentgenogram did not confirm this impression. Nonetheless bronchoscopy was done with the removal of a few bronchial plugs. In spite of this procedure, the patient became more comatose. Repeated bronchoscopy, frequent shifting of position and firm percussion of the chest was of no avail. A chest roentgenogram taken two days before death, shortly before sample No. 9 was drawn, showed massive atelectasis of the left lung. The patient expired thirteen days after admission to the hospital and ten days after his comatose state had developed. Autopsy revealed massive atelectasis and consolidation bilaterally with presence of pulmonary edema.

Fig. 2 shows the progress of this patient's respiratory acidosis. Initial samples showed approximately normal values, but sample No. 3, four days after admission, showed an elevated bicarbonate concentration of 81

volumes per cent indicating a compensated respiratory acidosis inasmuch as the pH was normal.

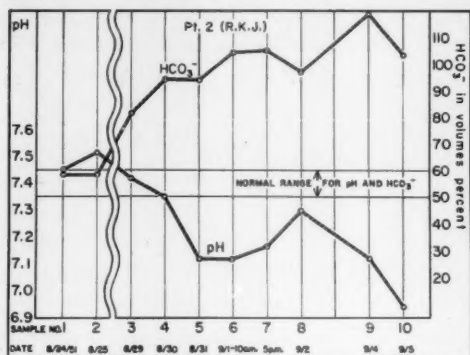


Fig. 2. Course of Respiratory Acidosis in Patient No. 2.—R.K.J.

However, the succeeding samples illustrate the patient's inability to remove the accumulating carbon dioxide and to prevent the progression of acidosis. Thus, sample No. 6 shows a pH of 7.12 and a bicarbonate of 104 volumes per cent. Sample No. 8 shows the effect of the addition of sodium lactate intravenously in an attempt to restore a more normal pH even though it was realized that the patient's prime need was adequate pulmonary ventilation. Samples No. 9 and No. 10 show continued accumulation of carbon dioxide and an increasingly severe respiratory acidosis which resulted from the irreversible pulmonary obstruction. Under oxygen supplementation, usually supplied by catheter through the tracheotomy canula, oxygenation remained at least marginal until the day of this patient's death.

Discussion

The fundamental difficulty observed in handling these patients with bulbar poliomyelitis involvement was that of respiratory obstruction, with inadequate strength of costal and diaphragmatic musculature playing a very minor role. In the earlier stages of the disease the respiratory obstruction was at the level of the paralyzed pharynx. Secretions would pool in the pharynx and then spill or be aspirated into the trachea and bronchi. In addition, the cough reflex was absent frequently so that

secretions normally removed would tend to remain in the bronchi. Poor fluid intake in these patients who were not diagnosed promptly would result in viscid secretions which more easily occluded the bronchial lumen.

The expected sequel of this earlier stage of respiratory obstruction was that of progressive occlusion of the more distal subdivisions of the respiratory tree. Thus, all of the ten patients who expired of bulbar poliomyelitis on whom autopsy was performed had postmortem evidence of atelectasis, with some having evidence of pneumonia and pulmonary edema in addition.

The clinical examples given serve to demonstrate the dual role of respirations: (1) Presentation of oxygen to the alveoli for diffusion across the alveolar membranes to the pulmonary blood and (2) exchange of tidal air sufficient to adequately remove the accumulated carbon dioxide. Various investigators have clearly shown that, of these two processes, oxygenation is the function more easily performed and can be adequate in the face of insufficient carbon dioxide removal. Carbon dioxide accumulation is the least considered complication in the patient having poliomyelitis with respiratory deficiency. Yet the expiration of CO₂ is essential to maintenance of the acid-base balance of the body. The relation of CO₂ to carbonic acid and to the bicarbonate ion is seen in the following equation: $\text{CO}_2 + \text{H}_2\text{O} = \text{H}_2\text{CO}_3 = \text{H}^+ + \text{HCO}_3^-$. Accumulation of CO₂ at a rate exceeding that of its removal by the lungs creates an increase in both the hydrogen and bicarbonate ions so that an acidosis with an increased bicarbonate concentration is seen. This respiratory acidosis is in contrast to the acidosis found in diabetic ketosis or in diarrhea, in which a low bicarbonate concentration is found. The only suitable treatment for respiratory acidosis is to improve respirations so as to remove the accumulated carbon dioxide. The effects of this acidosis are numerous, including an increased vascular permeability, which enhances pulmonary edema, and a decreased uptake of oxygen by the blood in the pulmonary circulation and also by the tissues in general. The principal clinical evidences of respiratory acidosis are those

of impairment of brain function, seen as restlessness, confusion and depression which may progress to coma.

In the second patient it is possible that the catheter in the tracheotomy canula was a factor retarding the elimination of CO_2 initially, as CO_2 diffuses more slowly through air than does oxygen. It is also probable that the CO_2 accumulating in the blood had a narcotic effect, contributing to the comatose state of this patient. Moreover, the respiratory acidosis created by the accumulating CO_2 could well have been a factor in promoting pulmonary vascular permeability changes which, in conjunction with the earlier obstruction by retained secretions in the bronchial tree and resultant local hypoxia, were sufficient to cause pulmonary edema.

Prevention and Treatment

The medical prophylaxis of these respiratory complications of bulbar poliomyelitis and the resultant respiratory acidosis should begin with the first signs of pharyngeal disability. Therefore, the early diagnosis of bulbar poliomyelitis is most urgent, as the physician who becomes alerted to this situation will be able to do much to prevent the unfavorable series of events which have been described in these patients. As soon as this diagnosis is considered, every effort must be made to prevent filling of the pharynx with mucous with subsequent spillage or aspiration of the latter into the respiratory tree. Attempts at oral fluid administration should be replaced by parenteral fluid therapy until such a patient has proved his ability to swallow without danger of regurgitation and so that adequate hydration, sufficient to prevent viscid secretions, will be maintained.

Prompt hospitalization is indicated so that the patient can be placed under close observation at all times. Facilities for aspirating the pharynx by mechanical suction should be present at the bedside and aspiration should be made a familiar and accepted procedure with the patient. If this can be done successfully pharyngeal suctioning will not cause the violent resistance and gagging which sometimes occasions the inspiration of pharyngeal contents into the

lungs. In this regard the nurse is a major part of successful prophylaxis. The art of successful aspiration of pooled pharyngeal secretions lies in her ability to provide a calm reassurance to her patient and in suctioning frequently but only briefly during expiration so as to avoid interference with respiration.

If the patient is kept in an atmosphere of humidified oxygen, placed in Trandelenburg position and adequately hydrated the pharyngeal secretions will be less viscid and their removal is accomplished more easily. Sedation is contraindicated during this acute phase of the illness. Atropine, which will increase the viscosity of these secretions, is specifically contraindicated, as all available evidence indicates that respiratory obstruction and pulmonary edema result from plugging of bronchi and bronchioles by thick secretions rather than from the increased amounts of more fluid secretions. Indeed, expectorants may well be of value in these patients.

If attending physicians and nurses are unable to keep the pharynx clear, a tracheotomy is indicated. Also, if the patient has already aspirated pharyngeal contents and there is evidence of obstruction in the respiratory tree, a tracheotomy should be performed so that access of the trachea and major bronchi by means of bronchoscopy is more readily obtained.

Adequacy of respiration should be evaluated repeatedly by estimation of the patient's color, pulse rate, mental state and rate, regularity and amplitude of respirations. Oximetry is a helpful facility in following the state of oxygenation. Also, the ever-present potential of respiratory acidosis emphasizes the advisability for early and repeated determinations of blood pH and bicarbonate concentration in order properly to evaluate the patient. As neither of these procedures is difficult they should both be available routinely in the hospital laboratory. Their use will reveal to the physician the presence of inadequate ventilation in such a patient, often before the latter is clearly detectable clinically. The physician may then act to improve respirations by whatever means indicated in the individual patient.

These methods of improving respirations include more careful suctioning, shifting the patient's position, tracheotomy, repeated bronchoscopic aspiration and, when respiratory impairment does not appear to be a result of obstruction or of inadequately removed secretions, the use of the respirator to increase the total volume of respiratory exchange. This latter circumstance may occur in the absence of demonstrable diaphragmatic or intercostal paralysis, and respiratory acidosis, with associated restlessness or coma, will then indicate inadequate respirations on the basis of an involved respiratory center.

Summary

1. The experience of caring for fifty-two children admitted to the Salt Lake General

Hospital with a diagnosis of bulbar poliomyelitis during the 1951 epidemic in Utah was discussed with reference to their respiratory complications. Two patients were discussed in detail to illustrate the insidious nature of inadequate ventilation in this disease.

2. The mechanism of respiratory obstruction and of respiratory acidosis was discussed.

3. Basic therapeutic measures useful in prevention and therapy of respiratory obstruction and respiratory acidosis are outlined. The advisability of employing blood pH and bicarbonate concentration as routine procedures in patients with acute bulbar poliomyelitis, as well as oximetry readings when possible, is stressed.

THE SURGICAL TREATMENT OF CORONARY ARTERIAL DISEASE*

CHARLES P. BAILEY, M.D., HOUCK E. BOLTON, M.D.,
and WILLIAM LIKOFF, M.D.
PHILADELPHIA, PENNSYLVANIA

Obliterative or occlusive disease of the coronary arterial system is one of the greatest present day causes of cardiac invalidism and death in the civilized world. The logical sequelae—angina pectoris, acute coronary occlusion, myocardial infarction, and myocardial aneurysm formation—are among the commonest of clinical entities. In most cases the underlying difficulty is atherosclerosis involving chiefly the large and the medium sized (muscle-coated) coronary arterial branches. This is a progressive and presently irreversible process which gradually diminishes and eventually must obliterate the entire normal source of coronary blood flow. The clinical course is frequently punctuated by acute episodes related to sudden closure of a major nutrient vessel, and death not infrequently occurs at that time or shortly thereafter. However, an occasional rare instance of prolonged survival after complete obliteration of both

main coronary arteries clearly demonstrates that normal auxiliary circulatory mechanisms may greatly modify the serious effects of occlusive disease of the coronary arteries.

These compensatory mechanisms may be considered as three: 1. The development of additional vascularity in the tissues at the base of the heart, and in adhesions which may form between the pericardium and the epicardium. 2. Presumptive overdevelopment of minute normal intracardiac passages which may exist between the cardiac chambers and the deeper myocardial sinuses. 3. Enlargement of the normally existing intercoronary communications—minute channels which connect the major coronary arterial branches by way of an extensive precapillary vascular network. It will be noted that the first two mechanisms are capable of augmenting the total volume of blood admitted to the myocardial circulation. The third mechanism merely improves the distribution of the diminished coronary blood flow, to some extent, thus to a degree replacing partially or com-

*From the Department of Thoracic Surgery, Hahnemann Medical College and Hospital of Philadelphia, Pennsylvania. This work was supported by the Mary Bailey Foundation and the U. S. Public Health Grant H-394. Presented at the Annual Meeting of the Utah State Medical Association, Salt Lake City, Utah, September 4-6, 1952.

pletely obstructed arterial channels. It is, however, a most important element in the preservation of life and in recovery subsequent to an acute coronary thrombosis.

Attempts by Beck, O'Shaughnessey, Thompson, and others to create a new blood supply to the surface of the heart by suturing vascularized tissues, or by the use of irritants (talc, asbestos, bone-meal, etc.) applied within the pericardium have only a limited usefulness. The question must always arise as to whether the new blood supply actually becomes anastomosed to the myocardial capillary bed and, if so, to what extent it can make up for the diminished natural blood supply. It is also felt that the necessary local surgical trauma and the chronic irritation of some of these foreign substances may stimulate an enlargement of the naturally occurring intercoronary communications.

Roberts and Beck, et al., have postulated that it might be possible appreciably to add to the myocardial capillary circulation by reversal of the flow of blood through the coronary sinus and its tributaries. This concept is based upon the experiments of Gross, and Fauteux showing that the coronary sinus can be sacrificed by ligation without producing death or permanent cardiac functional impairment. Since the deep myocardial or Thebesian veins are capable of an enlargement sufficient to drain the entire myocardial capillary bed subsequent to coronary sinus ligation, they reasoned that these deeper veins might also be able to drain off a considerable amount of additional arterial blood admitted to the capillary bed by way of a vascular graft placed between a systemic artery and the coronary sinus. The sinus will subsequently have been ligated at its orifice. Obviously a reversed blood flow in the coronary sinus would inevitably enter the myocardial capillaries since they are developmentally in direct communication with the ultimate ramifications of the tributaries of the coronary veins.

This concept of using one of the two myocardial venous drainage systems as a source of new arterial blood has been amply

justified by a considerable amount of experimental and clinical work by both Roberts and Beck. Truex and Angulo have independently demonstrated an anatomic vascular pattern in the hearts of both dog and man which would seem to provide a sound basis for this concept. While it has been possible to show that there are anastomoses between the tributaries of the coronary sinus, myocardial sinuses, Thebesian veins, and the lumen of the right atrium, it is felt that these communications might provide a safety-valve mechanism preventing over-engorgement of the myocardial capillaries when the coronary sinus is used as an auxiliary afferent blood passage-way. One may, therefore, conceive that the myocardium at least of the left ventricle is a "sponge" or "marsh" of blood consisting of an extensive capillary network and adjoined thin-walled vascular pools or sinuses. The muscle-fibriles are interspersed throughout

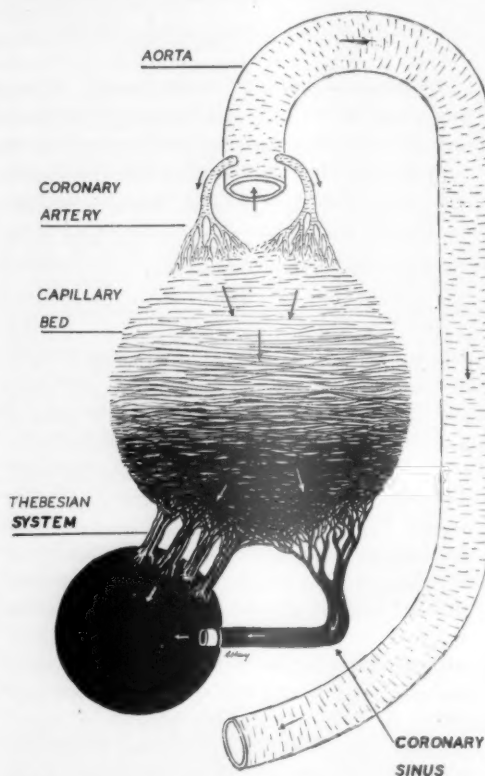


Fig. 1. Diagram of normal coronary circulation. Arrows indicate direction of blood flow. Darkened areas indicate the deoxygenated venous blood.

this capillary mesh. The blood content of this marsh at any given moment consists in part of fresh highly oxygenated blood recently supplied by the coronary arteries, of considerably deoxygenated blood about to be drained off by way of the tributaries of either the coronary sinus or the Thebesian veins, and of blood in various stages of deoxygenation between these extremes. See Fig. 1.

When atherosclerosis or any other obliterative process so affects the nutrient coronary arterial system (or a sizable portion of it) that there is a general (or limited) lack of adequate arterial blood replenishment to the myocardial "marsh," the blood flow through the "marsh" becomes somewhat stagnant and the over-all saturation of oxygen of this retained blood becomes very low. See Fig. 2. From then

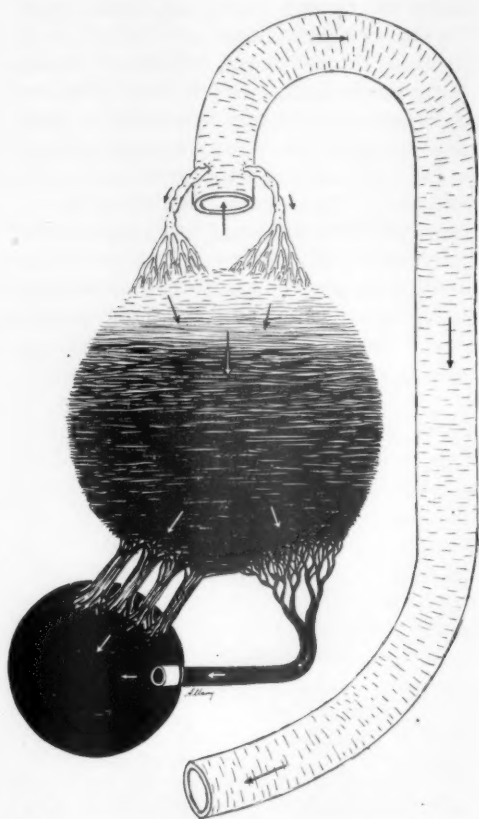


Fig. 2. Diagram of circulation with arterial occlusion. (Note greater amount of deoxygenated blood in the "marsh" due to stagnation).

on the myocardial fibers must contract under relatively anoxic conditions. The least exertion or additional demand for cardiac output may then precipitate an attack of angina pectoris or of actual ventricular fibrillation.

Medically, such patients cannot be greatly helped inasmuch as the existing myocardial anoxemia cannot be readily overcome, and since the arterial obliterative process is usually progressive. However, surgically, by utilizing the demonstrated fact that the deep myocardial venous system can readily become adjusted to drain

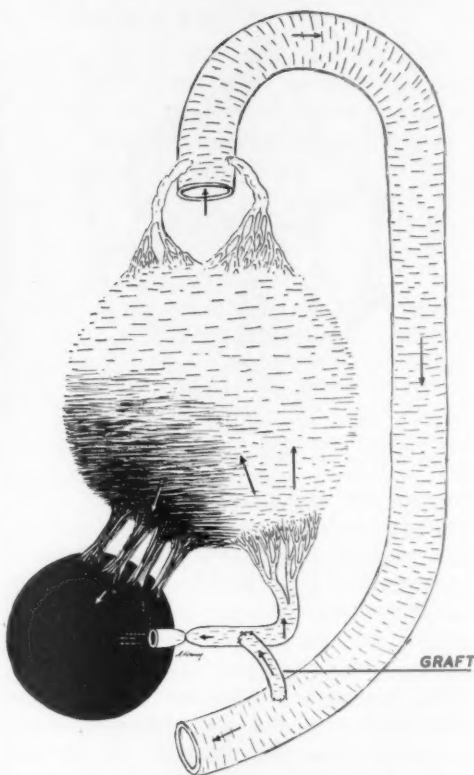


Fig. 3. Diagram of circulation after revascularization of the myocardium by means of a graft placed between the aorta and the coronary sinus.

off the entire myocardial marsh, it is possible to make use of the coronary sinus and its tributaries as an afferent system transporting additional arterial blood by retrograde flow directly into the capillary bed. See Fig. 3. There is no question of the possibility of causing this system to communi-

cate with the myocardial vascular marsh. Direct continuity with the capillary bed has existed from early embryonic life.

In order to avoid overdistention and engorgement of the capillary bed by this increased vascular supply, it is necessary to use a two-stage surgical technic. The first stage consists of communicating the aorta and the coronary sinus by a suitable vascular graft such as a large vein or a free segment of the left subclavian artery. See Fig. 4. The second stage, which is performed

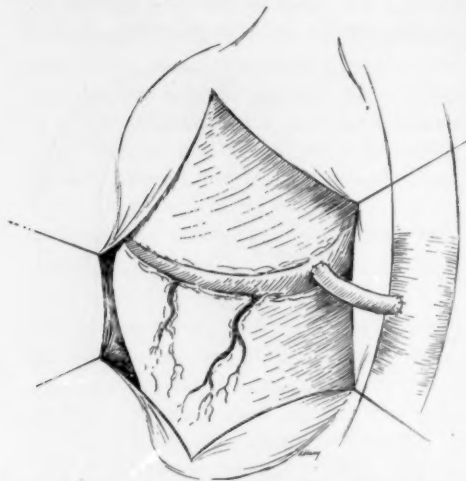


Fig. 4. Completed first stage, with the graft in place between the aorta and the coronary sinus.

three to six weeks later, consists of tying down the coronary sinus near its terminus to a residual lumen of 2-3 mm. diameter (measured by tying tightly down upon an adjacent measured probe which is subsequently removed). See Fig. 5.

A relative hypertension (50 mm. Hg. average) is produced in the sinus by the first stage procedure, but the additional blood is rapidly dissipated through the normal coronary sinus ostium into the right atrium. There is little or no backflow in the sinus after this stage. However, the hypertension in the coronary sinus and the consequent hampering of venous outflow gradually produces an enlargement of the capillary and venous channels of the Thebesian system. Subsequent partial ligation of the coronary sinus near its termination at the second stage is, therefore, well tolerated.

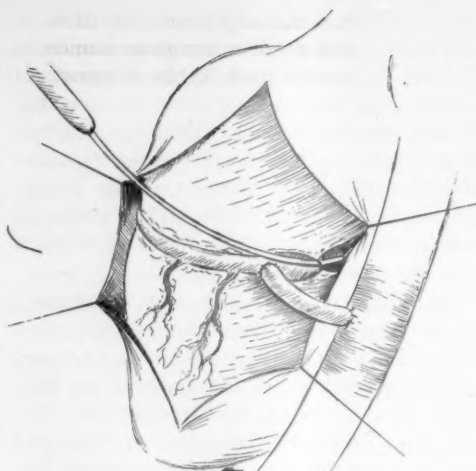


Fig. 5. Diagram showing partial occlusion of the coronary sinus at the second stage with the aid of the subsequently removed probe.

Retrograde flow of arterial blood becomes established at the second operative stage. The exact pattern of flow is modified by the varying nutrient need of different segments of the ventricular myocardium. Thus a segment with relatively good arterial blood supply will present a good pressure-head to the now afferent tributaries of the coronary sinus, thus permitting little or no entrance of additional blood into its portion of the capillary bed. On the other hand, segments with poor or nearly obliterated natural coronary arterial branches will present a very low pressure-head and so will receive a relatively much larger proportion of the additional blood admitted by the graft. Thus the new blood supply is differentially distributed to those portions of the myocardium which need it most. Should the respective needs of various portions of the myocardium subsequently change (by the development of the intercoronary communications or from subsequent progression of the underlying atherosclerotic process in certain of the segments) the new blood from the coronary sinus is automatically redistributed in proportion related to the needs of the respective portions of the myocardium.

The thought has been expressed by some that the remaining residual lumen of the coronary sinus following partial ligation at

the second stage and the readily demonstrable communications between the tributaries of the coronary sinus and the Thebesian system, especially the epicardial anastomoses to the anterior veins of the right ventricle, would permit all of the new blood supply to run off into the cardiac chambers, thus by-passing the capillary bed. While this would undoubtedly be true if the graft were very small, admitting only a trickle of additional blood, the large amount of blood flow provided by the average graft (5 mm. diameter) ensures sufficient pressure rise in each of these communications to drive a considerable proportion of the additional blood into each segment of the ventricular myocardium which is relatively ischemic and therefore presents a very low intrinsic pressure resistance against the force of the on-coming stream of graft-provided blood.

Whereas all previous attempts at revascularization of the heart (myopexy, omentopexy, pericardial poudrage, etc.) have essentially attempted only to add a sufficient increment of new blood to produce relief of anginal pain or perhaps to add some protection against sudden death from acute coronary occlusion or ventricular fibrillation, the Beck procedure contemplates partial or even complete replacement of the normal myocardial blood supply so that the patient may be restored essentially to normal health.

On the basis of the seeming soundness of the theoretical concept, the impressive accomplishments of Beck and co-workers in protecting animals from death and infarction subsequent to coronary ligation, and his initial promising clinical accomplishments, we were stimulated to establish a program of surgery for coronary arterial disease at the Hahnemann Hospital in Philadelphia and at the St. Michael's Hospital in Newark, New Jersey, in February, 1951. Dr. Claude Beck helped the program by flying East to perform the early series of operations. Up to the present time, operations have been performed in twenty-four such patients with three operative deaths. Thrombosis of the graft between the first

and second stages was a frequent occurrence in the first sixteen patients. Subsequent efforts embracing a modification of the original surgical technics have included removal of a small button of the aortic wall instead of simply making a linear incision in the thickened elastic aorta. This detail has appeared most helpful in preventing thrombosis of the graft. In addition, in our Clinic, the rubbery, non-kinkable left subclavian artery has recently been used as the vascular graft. Probably as a result of these and certain other minor technical modifications, we have had only one graft thrombosis in the last eight cases.

Choice of Cases for Operation

Obviously, no patient should be chosen for operation unless he can be clearly shown to have serious impairment of his coronary arterial flow. This may be determined by an unmistakable history of previous myocardial infarction, or of repeated definite attacks of angina pectoris. Nearly always, significant changes must be demonstrable in the electrocardiographic pattern.

On the other hand, while we may express the pious wish that arterialization of the coronary sinus could be performed on every patient with coronary insufficiency even into the terminal stages, we must accept reasonable limitations based upon practical considerations of operative mortality and of subsequent improvement. Obviously, patients with extensive myocardial fibrous replacement cannot expect significant restoration of health even if they survive operative intervention. At this early stage of our knowledge, our indications and contraindications must be essentially conservative. While certain persons who might have been surgically helped will undoubtedly thus be deprived of surgical benefit, the mortality and morbidity of the operation must be kept at a level of about 10 per cent in order that the whole method shall not be discredited.

We feel that one should not presently operate upon patients over the age of sixty years, or upon patients who have had more than two myocardial infarctions. The more recent infarction shall have been no closer

than six months. There must be no evidence of congestive failure and no considerable over-all cardiac enlargement. The blood pressure should not be very high, certainly not over 180 mm. of mercury systolic. In addition any associated condition, general or specific, which might influence operative survival or rehabilitation in a specific case, must be weighed on its own merits. Among these are emphysema, bronchiectasis, diabetes, obesity, renal failure, calcification of the aorta, etc.

Naturally, in dealing with such a chronic and somewhat unpredictable process, we cannot say that sufficient time has passed to permit reliable objective evaluation of

our operated cases, the earliest of which is two and one-half years postoperative. Nevertheless, the marked clinical improvement which we have observed in nearly all patients operated on with a graft which is open is such as to impress even the most conservative cardiologists. Certainly any medical therapeutic measure which held equal promise would already be subject to widespread employment in clinical cases. For these practical reasons, as well as the apparent theoretical soundness of the measure and its relative surgical safety, we feel that selected patients with coronary insufficiency should even now be offered this opportunity for restoration to health.

DIAGNOSIS AND TREATMENT OF THE IRRITABLE COLON SYNDROME

EDWARD J. DONOVAN, M.D.
DENVER

In discussing problems of the patient with the irritable colon syndrome, one of the first questions that should be answered is that of definition and terminology. In general, a patient can be considered to have an "irritable colon" when he has symptoms of colonic dysfunction for which no definite organic colonic disease can be found. This definition is not completely satisfactory as it does not take into account the symptoms of colonic dysfunction that may arise from an organic or functional disturbance in other organs. On the other hand, however, the definition is still a good one as it does emphasize a very important practical point—that the symptoms of colonic dysfunction can and do arise from a purely functional basis and without any underlying organic disease.

Many synonyms have been used to describe the condition such as "spastic colon," "mucous colitis," "nervous diarrhea," and "unstable colon." The latter term was suggested several years ago by Dr. Kantor and is probably a better one because in some phases of the disease there is decreased rather than increased irritability. Many years ago Dr. Bertrand Sippey also em-

phasized the fact that the term "colitis" was an incorrect one because in this disease there is no evidence of inflammation of the colon. The term "irritable colon," however, has been used most frequently to describe the condition and will be used here although it tends to focus one's attention mainly on the colonic irritability and dysfunction, although small bowel and upper gastrointestinal dysfunction and irritability are often a very important part of the symptom complex.

Because the gastrointestinal tract functions on a neuro-muscular-glandular basis it is very easy for it to become upset under emotional and irritative stimuli and because of this neuro-muscular-glandular basis we have two main groups of dysfunction produced.

1. **Neuro-Muscular:** This includes the cases in which the disturbance is primarily one of motor function. Since this appears as both contraction and relaxation, it manifests itself as either spasm or atony. The motor disturbance occurring with spasm can produce either constipation or diarrhea, but that occurring with atony can produce only constipation. The spasm of the intestine with associated dilatation proximal to the spasm will result in pain. The nausea, regurgitation, anorexia, and epigastric distress that accompanies this motor disturbance reflects the additional component of small bowel irritability and pyloro-

spasm that is frequently a part of the disease complex.

2. **Secretory:** This is characterized particularly by the secretion of excessive amounts of mucous such as is seen in the so-called "mucous colitis" or "mucous colic." In addition, there is often the accompanying excessive secretion of hydrochloric acid in many of these patients.

It is important to realize, however, that most patients with the irritable colon syndrome have a combination of both motor and secretory dysfunction and oversecretion of mucous rarely occurs without some accompanying motor dysfunction. The fundamental factor in the symptom complex, then, is an imbalance between the nervous and the muscular apparatus of the colon, which results in a disturbance in its mechanical and to a lesser degree in its secretory functions. This imbalance is manifested in the consciousness of the patient by various symptoms, the chief among which are abdominal discomfort or pain, gaseous distention and distress, and an abnormal elimination of fecal material.

Incidence

One may ask, Is this disease an important one? In the author's opinion, the failure of physicians to recognize it as a functional bowel disorder constitutes one of the greatest single sources of error in the diagnosis and treatment of the patient presenting with the complaint of abdominal pain. That this is so, is attested to by the large numbers of patients who have been subjected to needless surgical operations for adhesions, appendicitis, biliary tract disease, stomach and duodenal disorders, and even the pelvic organs, and who in spite of having parted with all these various organs still continue to complain of the very same symptoms for which the surgical procedure was undertaken. In 1941, Collins and Van Ordstrand from the Cleveland Clinic reviewed 1,000 consecutive cases of irritable colon from the records of the Cleveland Clinic. Prior to admission, 302 operations had been performed on 204 of the patients without any change in their individual symptoms. In confirmation of the above, was the report of Bockus and Willard, who in 1,000 consecutive case records of office patients found

that some type of functional colonic disorder was present in 46 per cent of them.

Etiology

The etiological factors involved in the production of this condition usually fall into one of two main groups, namely, psychogenic or abuse of the digestive tract. This was evidenced in a review of 1,000 cases of irritable colon by Dr. Sara M. Jordan in which 62 per cent showed a combination of the above two factors and in 38 per cent of the patients there was no associated nervous factors, only abuse of the digestive tract by the long continued use of cathartics and enemas. In addition to the above upper respiratory tract infections and various constitutional factors play their important role in the individual case.

Symptoms

The symptoms of a patient with colonic irritability vary considerably from patient to patient and in the same patient from time to time, and this factor alone is of considerable diagnostic importance along with the fact that most of them have had their symptoms for several years and still appear in good health. Ordinarily symptoms consist of abdominal pain or distress, gaseous dyspepsia (bloating, borborygmi, and excessive flatus), and some alteration in elimination of fecal material, which is manifested by constipation or diarrhea or a combination of the two. When symptoms are severe they may simulate those of many serious organic diseases of abdominal organs, such as biliary or renal colic, peptic ulcer, ulcerative colitis, or diverticulitis of the colon. The author has personally seen three physicians' wives who had become narcotic addicts as a result of continued administration of opiates by their husbands in an attempt to relieve their distress. In most cases the symptoms are not this severe, but they are so uncomfortable and distressing that patients go from one physician to another in hope of getting relief and when this is not obtained they finally end up in the hands of various colonic irrigation institutions in final hope of getting some measure of relief.

The pain or distress may vary from that of a severe colicky type of pain to a constant dull ache and may be localized to any of the abdominal quadrants or may be generalized over the entire lower abdomen. When it is localized to the left lower quadrant it is often diagnosed as being of pelvic origin or diverticulitis if the barium enema should show the presence of diverticula. When localized to the left upper quadrant it is often erroneously labeled as being of cardiac origin and the author has seen numerous patients who have been made cardiac neurotics and even more important given the erroneous diagnosis of angina pectoris because it was not realized that this condition may give pain in the left precordium and down the arm exactly like the distribution of angina pectoris. When distress is felt primarily in the right upper quadrant or epigastrium it may be erroneously diagnosed as gallbladder disease or peptic ulcer and diagnosis of gallbladder disease may be further strengthened by cholecystograms which show "slow emptying of the gallbladder." It is the author's firm opinion that contrary to much of medical teaching today there is no such thing as a medical gallbladder and unless the patient has had definite biliary colic requiring a hypodermic for its relief, associated with such additional symptoms as nausea, vomiting, jaundice, chills and fever, the dyspeptic symptoms of which the patient complains should not be attributed to the gallbladder but to the associated irritable colon. The presence of gallstones, however, may reflexly cause an irritable colon or aggravate one that is already present. This associated irritable colon must be treated postoperatively if the patient is to obtain the relief he is entitled to by a skillful surgical procedure. This is adequately attested to by reports of surgeons who have operated upon large numbers of patients for non-calculous biliary disease and have found that only about one-third of patients get relief of dyspeptic symptoms for which the gallbladder was removed. When the distress is localized mainly to the right lower quadrant it again is often erroneously diag-

nosed as coming from the female organs or appendix. In about one-third of the patients distress is felt in the lower back, and these patients are often put to a series of expensive spine x-rays and orthopedic consultations without relief of their back pain until upon the institution of adequate bowel management the pains are relieved where previous orthopedic measures have failed.

The pain or distress has certain definite characteristics other than that it is shifting in character and variable. It is aggravated by strong cathartics, raw fruits and vegetables, by nervous tension and fatigue, and by upper respiratory infections. Greatest discomfort is often felt during the hours of greatest intestinal activity, such as in early morning hours and immediately after eating (gastro-colic reflex). Many patients will comment that they hate to eat because eating precipitates distress or bloating, and this is another important point in the differential diagnosis from peptic ulcer. Because of this failure to eat and the rapid transit time through the intestinal tract, many of them suffer from malnutrition, weight loss, and mild vitamin deficiencies.

Diagnosis

Differential diagnosis of irritable colon must be made by the process of exclusion as there are many causes for colonic dysfunction. Particular studies that are indicated in each case will be dictated by a careful analysis of that individual problem. It must not be forgotten that lesions in the genitourinary tract may be responsible for gastrointestinal symptoms and if the patient has any symptoms that are referable to the urinary tract, as well as the digestive tract, adequate examination of the urinary tract should precede study of the gastrointestinal tract.

Competent x-ray study serves to exclude an organic disease and the ability to reassure both patient and attending physician on this score has additional therapeutic value. In addition, it is also a means of properly evaluating the motor disturbance and the general condition of irritability of the colon. Roentgenologic examination is a helpful diagnostic aid in about 75 per cent of cases

by revealing with barium enema and a standard technic the following deviations from normal, such as excessive speed or delay in filling time, excessive narrowness or width in caliber, variations in length and tortuosity of the atonic colon, excessive increase or complete absence in the number of haustrations, absence of sensation or severe distress in filling and too slow or too rapid emptying. The barium enema method is unphysiologic to be sure, but a normal standard for this procedure can be established and these standards of normality are useful in diagnosis of the condition. Criteria for x-ray diagnosis are available only if there is no preparation of the colon for examination as the usual procedure of purgation of the colon with castor oil before the barium enema usually produces a transient irritability of the normal colon. Although many radiologists will disagree with the above, the author after a personal experience in gastrointestinal fluoroscopy of over 3,000 patients with particular attention being paid to the above deviations has found the barium enema examination a very useful diagnostic aid. In some cases, films taken after ingestion of the barium meal also indicate the condition by rapid passage of the barium meal, often as far as the splenic flexure and even to the rectum in three hours; whereas, normal time for this progression is 12-24 hours. In such cases there may be additional supplementary evidence in the segmented appearance of the small intestine, and in the residue of barium in the stomach in spite of rapid passage of the head of the meal through the colon. This three hour post-meal picture of retention of barium in the stomach with the head of the meal in the transverse or descending colon indicates hypermotility of the small bowel and pylorospasm which are so often associated with irritable colon. These readily observable facts explain malnutrition and symptoms of nausea and anorexia which are not infrequently found in this condition.

The physical examination is important in helping to exclude organic disease. The positive findings often include a tender rope-

like sigmoid colon, or a distended tender cecum. Many patients show a peculiar type of abdominal neuralgia localized to superficial tissues of the abdominal wall, and recognition of this type of tenderness is most important as it helps to exclude an intra-abdominal organic disease as cause of the patient's symptoms. Proctoscopic examination shows no actual evidence of inflammation or ulceration, nor presence of blood or pus. However, there is often marked intensity of redness of the mucosa and a glariness from excessive secretion of mucus. In those cases with a long standing use of the cascara type of laxatives, a peculiar brownish discoloration of the mucosa may be seen. Digital examination often reveals anal spasm, particularly in those cases with a long standing use of laxatives.

Examination of the stools is important chiefly for consistency of the stool. There is usually some abnormality of the stool such as loose watery stools, unformed stools, or narrow ribbon or lead pencil sized stools, or hard dry "sheep pellets." Gastric analysis is also important in that treatment of occasional attendant hyperchlorhydria or achlorhydria may be of value.

Treatment

Rest is the keynote of therapy in these patients. This means both physical and mental rest for the patient and rest for the colon. In most patients a great deal of attention must be paid to management of psychic and emotional factors involved. This is best accomplished first of all by giving the patient adequate reassurance that he does not have any serious organic disease, particularly cancer, as so many of these patients suffer from cancerphobia. The psychotherapy needed can be best given by a personal understanding and sympathetic physician who will take time to listen to the patient's troubles and help him to understand them and adjust to situations that cannot be changed. Of greatest value is time spent in giving the patient an explanation of normal colonic physiology in simple easily understood terms and explaining how an alteration in this coordinated mechanism accounts for symptoms that he is having. In an occa-

sional case the colonic symptoms are the somatic expression of a deep seated psychic problem and in these cases assistance of a well-trained psychiatrist is often needed.

Rest for the colon begins with breaking down of excessive bowel consciousness that so many of these people have. The use of all cathartics, colonic irrigations and enemas must be stopped and this is most easily accomplished by an explanation to the patient of their harmful effects and how they interfere with normal reflexes and coordinated mechanisms of the colon. In their place should be given detailed instructions on use of rectal instillations of warm oil as a retention lubricant at bedtime. Dietary management of these patients is most important and begins with removal of all fried greasy foods from the diet as well as raw fruits and vegetables. A low residue diet is used at the beginning of treatment in those patients with marked symptoms of irritability because the bowel is often so hyperirritable and sensitive that it will not tolerate rough coarse foods without exacerbation of symptoms. When the irritable stage has subsided the diet may be gradually changed to a high residue type of diet containing natural bulk foods such as vegetables, whole grain bread and cereals, and salads. Fruits and vegetables may be added early if they are cooked, but raw fruits and vegetables should not be eaten until the later stages. In those patients whose main symptom is diarrhea, addition of fruits and vegetables must be made carefully. Since the rate of absorption of water from the bowel is proportional to body hydration, adequate fluid intake facilitates lubrication of the bowel and prevents hardening of feces. An adequate intake of fluids, therefore, should be prescribed and this can be met by taking four to six glasses of water daily.

Sedatives and antispasmodics play a very important part in control of excessive emotional and parasympathetic stimuli and this need is best met by use of small doses of phenobarbital and antispasmodics. In contrast to much experimental work showing lack of effect of the many antispasmodic preparations on colonic motility from a clin-

ical standpoint, they seem to help a good deal in many of these patients. One of the best and cheapest is tincture of belladonna given in adequate dosage. Vitamin supplements should be given to patients who present evidence of increased motility which over a period of time interferes with adequate absorption and in those patients who have prescribed for themselves dietary restrictions because of distress that was attributed to various foods. If the patient does not respond to an ambulatory program, he will nearly always obtain a good response from a period of strict hospital bowel management.

Summary

Importance of the irritable colon in diagnosis of abdominal pain and distress has been emphasized and the main characteristics and diagnostic aids discussed. Methods of treatment including physical, mental, and colonic rest and judicious use of sedatives and antispasmodics in addition to elimination of cathartics and enemas has been emphasized.

POSTGRADUATE TELEVISION CLINICS

The Division of Graduate and Postgraduate Medical Education, University of Utah College of Medicine, supported in part by a grant from the W. K. Kellogg Foundation, has utilized a new approach to give the physicians an opportunity to participate in clinics and rounds. In cooperation with KDYL-TV, Salt Lake City, Utah, a series of Postgraduate Television Clinics is being presented weekly.

The first program was telecast November 10, 1953. These clinics are presented in the usual manner and are televised from the amphitheater of the Salt Lake General Hospital. The programs appear at 7:00 to 8:00 a.m., two hours before the regular broadcast day of KDYL-TV begins. Even though this broadcast is on an open circuit, the clinics are produced on a postgraduate level.

Announcement of the time of broadcast was only to physicians, but it is expected that a certain number of the lay population might tune in accidentally. Audience participation in this program is encouraged and unlisted telephone service directly to the broadcast amphitheater is provided so that doctors may ask questions during the program. Only the physicians in the area will be given the phone number for this type of participation.

This series of clinics represents the initial use of open circuit television for postgraduate medical education and is considered an experiment in medical education. Evaluation of Postgraduate Television Clinics is being carried out and will be published after completion of the present series.

INCOMING PRESIDENT'S ADDRESS*

FRANK K. BARTLETT, M.D.
OGDEN

Partly due to the presence and growth of people around us with ideas inimical to the practice of medicine as we have practiced it and as we believe it should be practiced, the American Medical Association and all other State Medical Societies have launched a program of public welfare measures and attempted the development of favorable public relations not seen before in the entire history of medicine.

The complexity of the Utah State Medical Association has increased and its objectives have multiplied to such an extent that no one can suddenly step into the Presidency and expect to grasp and understand the details of its entire workings in one fleeting year. The Society's interests in the past few years have been combined and integrated with those of all other health groups in the State. We are actively interested in school, rural and other public health programs, hospital relationship, in legislation affecting the public health and the medical profession, in nursing, in the Utah State Medical School, in all aspects of a rapidly growing prepaid health insurance, in old age care, in public welfare and in other matters.

We are engaged in a positive campaign of maintaining and improving the health of all the people of this State and also of retaining their full confidence in us as individual physicians and in the professions as a whole. It is idle for us to hope or believe that we can turn the clock back and practice in the quiet way of twenty-five years ago. We will always have from now on an increasing responsibility in holding our end up in all activities concerning the public health and welfare. Our entire way of life is altered. The public is looking to medical men to take the lead and find the solution of their health problems and the related socio-economic implications. If we do not accept this challenge, their solution will be undertaken by some non-medical group, and we will be very unhappy about it.

I would like to re-state what is believed

and accepted in our society, that it is not only an honor but an obligation for each committee-man to participate fully in his committee and to work diligently on the subject assigned to him. Indifference and failure to attend meetings without a good excuse is in fact a failure to discharge his obligation to his society. One of the finest bits of advice that William Osler has given to the medical fraternity is for all members to attend the meetings of his society regularly, freely participate and give liberally of his time. Too often the willing few are carrying the message to Garcia.

Within my memory over the past forty years of practice there have occurred a continuing number of spectacular changes in the practice of scientific medicine, comparable to the rate of change we find in all other aspects of our lives. It is a fact that no one can practice the medicine he was taught in his medical school for more than a very short period after his graduation. In the early part of the century the physician was highly regarded by the public as having a profound knowledge of health and disease. He was regarded as a benevolent healer and counselor of the family in personal affairs. His was a warm personal friendship with his clients, and not abstract and impersonal as he is sometimes and by some people regarded now. He was untroubled with socio-economic problems—in fact, there were none as compared with today. The cost of medical care was nominal.

The physician continued in this atmosphere of quiet, scientific dignity, concerned mostly with keeping abreast of the increasing advances of medicine, and interested personally in his patients' welfare. Almost overnight man's longevity increased from 40 to 63 years. The vast array of new diagnostic procedures, increased hospitalization and the introduction of numerous elective medical and surgical operations ran the cost of medical care to unprecedented highs. There was no prepayment insurance coverage. The will to survive being paramount in the lives of all people, the sacrifice of

*Read before the 59th Annual Meeting, House of Delegates of the Utah State Medical Association, September 9, 1953, at Salt Lake City.

their savings and property did not deter them from making the effort to keep well.

Medicine has changed in these few years from the leisurely pursuit of an age-old practice to a lively and extensive "business." The advances in scientific practice far outdistanced any planning in the economic field to meet the spiralling costs; in fact, the medical profession and the insurance companies were slumbering in the economic field. There was discontent among the masses even though medical costs had not risen proportionally to costs in other fields. The general cost of living according to the Department of Labor had risen 90 per cent from 1935 to 1939 while medical costs had risen only 65 per cent. But let us not fail to remember that medical costs are unforeseen and a more difficult burden to bear by a sick family. Costs were often pauperizing, especially in catastrophic and chronic illness. There were inferences and accusations by certain groups that the medical profession was getting too big a "take." We had to absorb the shock; words and statistics were unsatisfactory explanations.

It was in this atmosphere and within the past ten years that a socialistic minded government spread its paternalistic wings over the medical field, bent on hatching a regimented medicine of the Ewing type. Before we knew it we almost lost our liberty and freedom.

In the past three years, as you well remember, under the brilliant leadership of the American Medical Association, the physicians over the country and their patients fought a successful political campaign, soundly defeating, at least for the moment, those political groups bent on the control of medical education and practice. This amazing respect and support of the profession by the people has underlined some grave responsibilities for us toward that public.

For the present the political philosophy of the nation is reversed. Ten days ago Mrs. Oveta Culp Hobby, Secretary of Health, Education and Welfare, stated that socialized medicine was making no headway in Washington, and that the vast majority of the people wanted none of it. On the other hand, if you read Congressman Howard Buffet's "Backing Into Socialized Medicine,"

of May, 1953, you will have the impression that we are edging into socialized medicine by way of militarism—whether we wish it or not. The C.I.O. advocated in their last meeting of 1952 a nationalization of medicine not unlike that found in England.

At the present our organization is on trial in the medical economic field to see whether or not it can ease the burden of the high cost of medical care for all people of moderate means and particularly for those who need care most and can least afford it.

The best thinkers of our profession question any further increase in physicians' fees now, most especially when the future security of medicine is still uncertain. We must maintain this attitude in our state organization. The practice of medicine is different from the pursuit of all other vocations. We are practicing a profession, not driving a trade. It is a matter of whether or not we have the leadership to take the initiative in all matters of health in this country—especially in the economic field.

In the past few years the development of prepayment health insurance has issued as the most hopeful means of solving our medical cost problem.

One medical observer goes so far as to state that "the future of medicine and to a degree the future of democracy will be shaped by what happens to voluntary health insurance plans." It is to our distinct advantage to cooperate with the Medical Service Bureau and other insurance companies.

In Utah, as elsewhere, poor insurance policies (often issued through the mail), misrepresentation by agents, and a lack of understanding by the patient of what a policy really covers, often leads to the discredit of the medical profession and to dissatisfaction with the prepayment principle. The physician's understanding of and his ability to so interpret these plans to his patient is necessary for the protection of the patient, the insurance company and himself.

We are hearing so much about the importance of public relations that it often loses its meaning and significance. Briefly, there are two aspects to public relations. One is the personal relationship of the doctor to his patient, where his efficiency,

his tact, kindness and generosity form a bond the like of which is seen only between members of a family. There is no creed, color or economic bar to that relationship. This is the thing young doctors must have and cultivate. Lacking these qualities, the physician should never have entered the practice of medicine.

The other aspect of public relations is in our now very active participation in all public health questions. It has many facets. Our national organization is showing brilliant leadership in this very field. All state organizations, including our own, are deeply involved and have many going programs and objectives to improve the general health of a community, educate them in medical matters, banish fear and ignorance and restore faith and hope.

The public relations of this Association through the press, the radio, the television have been considerable and excellent in the recent past and much favorable comment has been had from within the organization and the public at large. We of the Association are particularly grateful for an intelligent and understanding press.

We do not want public relations through the above media to get bogged down, stereotyped or in any way to fail to continue eliciting the public interest. We must use these media to their fullest extent in connection with all the various committee endeavors and the Auxiliary. It would be wise for all committees connected with public relations to get together every year and to reappraise their objectives, go over the programs in detail and assess the methods of their operations. For these media are the most sensitive and powerful contacts of the Association and the general public. Utah has been one of the outstanding states in the Union for its progressive activities in public relations.

A few practical ways of improving our public relations are:

1. Let us freely advise the public that Utah physicians will see that no person will go without necessary medical aid regardless of his ability to pay.
2. Let the people know of our Mediation Committee and what it stands for.
3. Let each physician interpret the in-

surance policies of his patients for him so that there will be no misunderstanding of what that policy covers in hospital costs and medical fees.

4. Talk over the costs of a proposed operation with your patient. Do not avoid it. Approach the subject yourself.

5. In case of consultation, be sure that the patient understands that this is, or is not, an additional expense and to what extent.

6. Itemize your bill.

7. Keep careful hospital records; you may need them.

8. Compromise a bill rather than insist upon its payment. This is where one-half of the malpractice suits originate.

9. Always consider the urgency and difficulties of your service as well as the economic status of the patient before deciding upon the amount of your bill.

10. Keep intra-organization squabbles to ourselves.

Without fear of being repetitious I feel obligated to reiterate what has been said in the House of Delegates of the American Medical Association and what is acknowledged in all the state societies, the fact that we in Utah have to face the problem of self-discipline within the profession. Recently, as you know, within a national political party, isolated instances of known graft and corruption, unrevealed at the time to the public and unpunished, have done more to discredit and demoralize that party than all of its otherwise objectionable policies. Within our own organization it is known that a very small percentage of doctors are unethical. They overcharge or charge all the traffic will bear, racketeer on the insurance companies, exploit patients with unnecessary operations or treatments, fail to respond to emergencies, and in other ways fail to practice good medicine. Sooner or later these cases come to the attention of the Society and are turned over to the Supervisory Committee for accounting and unsympathetic punishment. These individuals are a discredit to and bring unjust criticism upon the entire profession.

A hundred years ago the Boston Medical and Surgical Journal stated: "There is a prodigious amount of quackery conducted

under the guise of a strong sense of duty which compels certain individual physicians to disengage themselves from the trammels of society discipline and strike out an independent course of their own." In this day of education and the wide diffusion of knowledge, it is amazing how many people are taken in by the convincing though specious arguments of the quacks and cultists. It would be easier and less contentious for the medical profession in Utah to disregard and avoid the whole affair. But to so compromise ourselves by silence is almost comparable to approval of their practices.

There are two new projects that your Society will launch this year, both of which can be classified not only as good public relations but which will result in considerable benefit to the public. I would like to outline them briefly to you:

1. A safety program or "a vaccination against accidents," has unlimited possibilities. Twenty years ago communicable diseases were the leading cause of death in all age groups. Today preventable accidents are the top killers in certain age groups. Over 500 accidental deaths have occurred in Utah in each of the past five years. There were 81 accidental deaths in Utah in 1952 in the 1 to 4 year age group; 40 of these deaths occurred in their own homes while the balance were killed mostly by motor vehicles. Those occurring in the home include burns, drownings, poisoning, falls, choking on aspirated foreign material, auto accidents in private driveways and other causes. Of the 119 accidental deaths in the over 65 age group in 1952, 63 died directly or indirectly from accidents in their supposedly safe homes. For every accidental death there are 50 or more non-fatal accidents with from slight to permanent injury and disability.

2. Care of the aged is another project to be initiated by the Society this year and which has a real need. While the care of the aged is not strictly a medical one there is no doubt about its being an increasingly acute problem. At present one out of every 13 of our population is over 65 years of age. There are over 12 million past the age of 65 in the U. S. A. Many oldsters have the

means and the home and the mental ability to take care of themselves. Some are indigent, homeless and thrown on society. Many become sick and mentally feeble. They need to end their days in some more pleasant and useful manner than 50 per cent of them now do. Every doctor has seen numbers of these unfortunates who could do something in a helpful way within an institution designed for them and still maintain their cheer and dignity to the end. In Logan one of the finest projects in Utah was started by a few thoughtful and considerate citizens. Now, with a large enrollment of the population behind it and with the help of the county for indigents, they in Logan have changed a home for the aged into a "Sunshine Terrace," a veritable haven of happiness and contentment. In Ogden we have a county poor farm and several crowded rest homes with minimal standards, privacy and comfort. Salt Lake has a similar situation as does the Provo area, the central and southern districts of the State.

There is a real need for a survey and action on this situation wherein increasing numbers of old people, many of whom are chronically ill, are groping about for a place of contentment. In fact, the opinion has been stressed that there is as great a responsibility in the care of this very important segment of our society as there is in the health problems in the younger age groups. The devastating loneliness, hopelessness and apathy of these erstwhile useful citizens, mothers of fine families, fathers of industry, is a challenge today to our community. Everyone up in Cache County talks of "Sunshine Terrace" like a man talks about his laughing, blue-eyed daughter. There is more interest in this particular subject than is apparent on the surface.

In closing, let me say that the care with which medical students are selected today for admission to medical school presages their scholarship and fitness to make good physicians. As one mingles with the interns and residents and the young men of our Society one need have no great concern about their aptness and honesty, nor about the future of the profession in this state.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement which appears in *New and Nonofficial Remedies*, 1953, Philadelphia, J. B. Lippincott Company, pp. 171-173, 1953.)

METHANTHELINE BROMIDE.—*Banthine Bromide* (Searle)

β -Diethylmethylaminoethyl 9-xanthenecarboxylate bromide

Actions and Uses.—Methantheline bromide, a parasympatholytic agent, produces the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also cause less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastro-intestinal and genito-urinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric, and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and

therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degrees may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

Dosage.—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial dose for adults, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals, and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

G. D. SEARLE & Co.

Powder Banthine Bromide: 2 cc. ampuls. 50 mg.

Tablets Banthine Bromide: 50 mg.

Organization

National Affairs - Proceedings - Programs - Society Notices - News - Auxiliary

COLORADO State Medical Society

ABSTRACT OF MINUTES*

HOUSE OF DELEGATES OF THE COLORADO STATE MEDICAL SOCIETY

83rd Annual Session—September 29, 30;
October 1, 2, 1953—Shirley-Savoy
Hotel, Denver

FIRST MEETING—Tuesday, September 29, 1953

Dr. Eugene B. Ley of Pueblo, Vice-Speaker, called the House to order at 10:00 a.m. in the Colorado Room and recognized Dr. I. E. Hendryson, Chairman of the Credentials Committee. Dr. Hendryson presented the Committee's Report as printed in the Handbook and supplemented it by recommending that Dr. Arthur B. Gjellum of Del Norte be seated as an alternate delegate to Dr. George Davis from the San Luis Valley Medical Society.

Sixty accredited delegates (more than a quorum) answered the roll call. Before adjournment of the first meeting sixty-six delegates reported present.

On motion, the reports of the Credentials Committee were adopted.

Address of Speaker

Speaker Kenneth H. Beebe, addressed the House as follows:

Just who do you think runs the Colorado State Medical Society? The Board of Trustees? The President? The other Officers of the State Society? Harvey Sethman, our very capable Executive Secretary, and his staff at 835 Republic Building?

No! You, the Delegates.

So now and for the next four days we will listen to the reports of the various Officers and Committees of this past year. We, individually and through our Reference Committee, will judge how well the needs of the doctors of Colorado have been fulfilled during the past year.

We are here to discuss and to plan the requirements of the health of the Colorado citizens, and seek for better methods so we, as physicians and surgeons, through our State Medical Society, may meet these requirements.

Watch for these things in particular: Both through an Interim Committee appointed by the House last year and through a Committee appointed by the Board of Trustees there will be many suggestions for improvements in our officer and committee setups. Study them. They may not all be good.

A new method of budget which has been recommended by our C.P.A. will be presented. The AMA House of Delegates wants our recommendations on several problems. How can we help solve our rural health problem?

*Condensed from the shorthand and sound recorded record of H. E. Dennis, Certified Shorthand Reporter. Reports referred to but not reproduced herein were distributed to all members of the House of Delegates in advance of the Annual Session in the printed "House of Delegates Handbook" or were distributed to all members of the House in mimeographed form. Copies of all such reports are on file in the Executive Office of the Society, available for study by any member of the Society.

Attend the Reference Committee on Public Health and let us give the Legislative Committee some positive thinking on stream pollution, on our mushrooming public health department, and any other local health problem that the local societies have not been able to solve.

Are you satisfied with Blue Shield? If not, let's report to the Public Relations Reference Committee.

Okay. It is our House of Delegates. It is our State Medical Society. It is our AMA. In fact, it is our profession and our life. Now what are we going to do about it? It is our future.

Speaker Beebe assumed the Chair and he and Vice Speaker Ley alternated in presiding the remainder of the session.

On motion regularly seconded and adopted without dissent, the Minutes of the 82nd Annual Session of the House were adopted without correction as published in the November, 1952, issue of the Rocky Mountain Medical Journal.

Reference Committees for 1953 were revised by Speaker Beebe to replace absentees.

Reports of Board of Trustees

Chairman McKinnie L. Phelps presented the annual report of the Board of Trustees as printed in the Handbook. He also presented the mimeographed annual audit of the Society's books by the firm of Collins, Peabody & Masters, Certified Public Accountants, a mimeographed supplemental report of the Board covering actions taken subsequent to publication of the Handbook, a mimeographed report from the auditors on the Colorado Medical Foundation, and a mimeographed supplement including the report of the special Organization Study Committee. All mimeographed reports were distributed to members of the House. Chairman Phelps reported verbally that the Board had, with regret, accepted the resignation of Miss Helen Kearney, Assistant Executive Secretary, at a special meeting September 28.

In discussion Dr. James M. Perkins, Secretary of the Denver Medical Society, was granted the floor to present resolutions on behalf of that Society relating to the Trustees' reports as follows:

Resolution

Whereas, The Council of Delegates of the Denver Medical Society at its meeting held September 17, 1953, seriously considered and discussed the recommendations made by the American Medical Association House of Delegates at its June, 1952, meeting relative to the question of permitting doctors of medicine to teach in certain professional schools; and,

Whereas, It was pointed out that AMA's Council on Education and Hospitals had been refused permission to inspect and credit these professional schools;

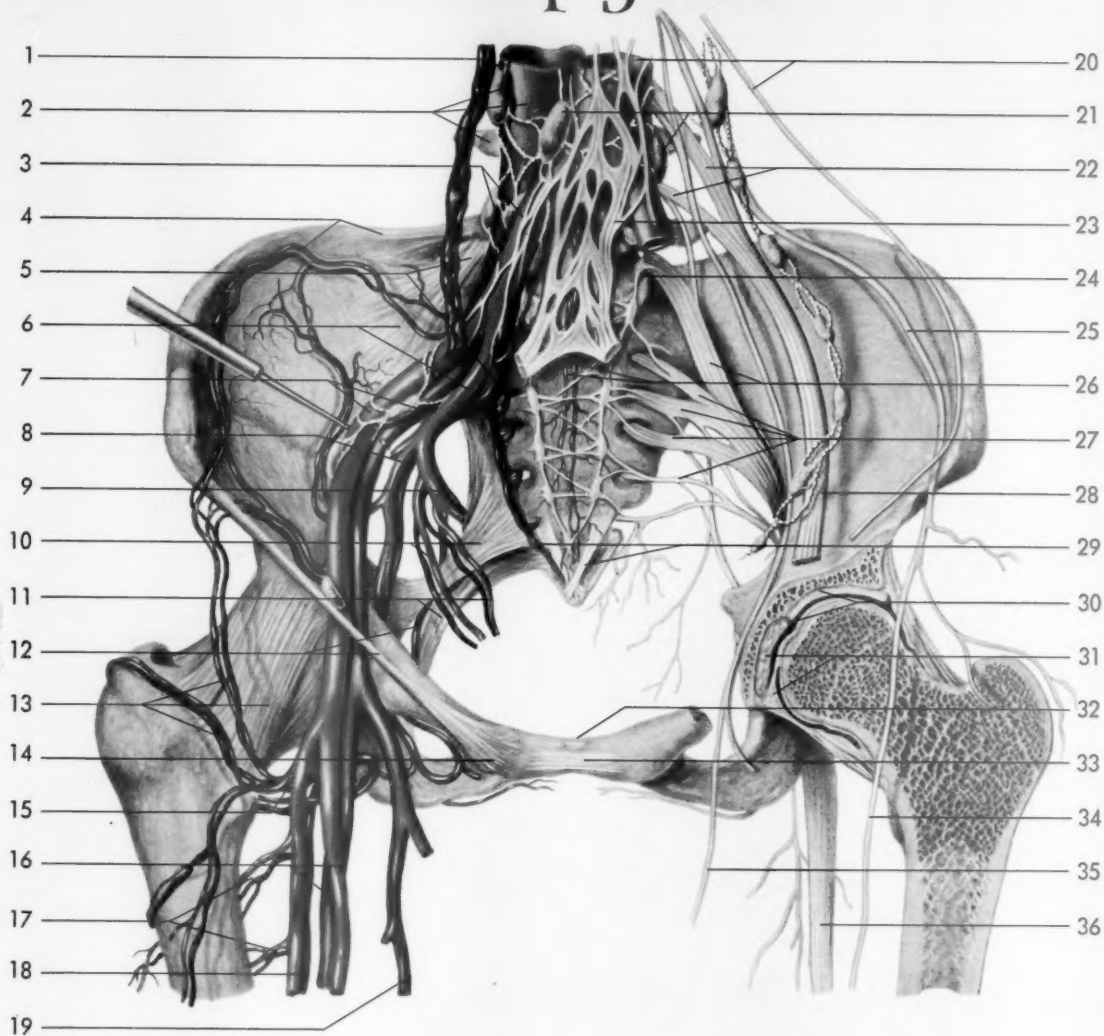
Therefore, Be It Resolved, That our Delegates to the American Medical Association be informed of the fact that until such time as the AMA is permitted to inspect certain professional schools the Colorado State Medical Society disapproves the AMA's recommendation to permit doctors of medicine to teach in these schools.

Resolution

Whereas, The Council of Delegates of the Denver Medical Society at its meeting held September 17, 1953, seriously considered and discussed the recommendation made to the House of Delegates in September, 1952, that the Board of Trustees of the State Medical Society be increased from nine to eleven members by addition of the immediate two past presidents; and,

Whereas, The office of the President of the State Medical Society at the present time requires the

Anatomy of the Pelvis and Hip Joint



- 1 Ovarian artery and vein
- 2 Vena cava; lumbar lymph nodes
- 3 Right common iliac artery and vein
- 4 Iliolumbar ligament; branches of iliolumbar artery and vein
- 5 Lumbosacral ligament; superior gluteal artery and vein
- 6 Anterior sacroiliac ligament; internal iliac (hypogastric) artery
- 7 External iliac artery and vein

- 8 Obturator artery and vein
- 9 Inferior gluteal artery and vein
- 10 Sacrospinous ligament; uterine artery and vein
- 11 Sacrotuberous ligament; vaginal artery and vein
- 12 Inguinal ligament; internal pudendal artery
- 13 Iliofemoral ligament; branches of lateral femoral circumflex artery and vein
- 14 Lacunar ligament
- 15 Lateral femoral circumflex artery and vein
- 16 Femoral artery and vein

- 17 Perforating arteries and veins
- 18 Deep femoral artery and vein
- 19 Great saphenous vein
- 20 Aorta; ilioinguinal nerve
- 21 Lateral aortic lymph nodes
- 22 Lumbar nerves
- 23 Hypogastric sympathetic plexus
- 24 Sympathetic trunk
- 25 Lateral femoral cutaneous nerve
- 26 Middle sacral artery and vein; lumbosacral trunk

- 27 Sacral nerves
- 28 Femoral nerve
- 29 Lateral sacral artery and vein; anterior sacrococcygeal ligament
- 30 Lunate articular cartilage; joint cavity
- 31 Acetabular fat pad; ligamentum teres
- 32 Interpubic fibrocartilage
- 33 Superior pubic ligament
- 34 Anterior branch of lateral femoral cutaneous nerve
- 35 Obturator nerve
- 36 Great sciatic nerve

This is one of a series of paintings by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Lederle

*Many infections attack the pelvic organs,
as well as the surrounding bony structures.*

Aureomycin^{*}

CHLORTETRACYCLINE

*promptly controls susceptible infections
involving the bladder, the reproductive organs,
the blood and lymph vessels, the pelvic
peritoneum, the pelvic bones and the hip joints.
The frozen pelvis and the pelvic cripple
are becoming things of the past and
Aureomycin has often proved life-saving.*

* TRADE-MARK

LEDERLE LABORATORIES DIVISION

AMERICAN *Cyanamid* COMPANY

30 Rockefeller Plaza, New York 20, N.Y.

greater portion of the individual's time for a period of two years and obligating him to serve another two years would be a considerable hardship, and,

Whereas, The standing rule which has been in force during the past year has made it possible for these two men to attend as ex-officio members and thereby permit the Society to benefit by their counsel and advice, but at the same time conserving their time by not making attendance mandatory throughout all of the sessions of the Board of Trustees;

Therefore, Be It Resolved, That the Denver Medical Society recommends to the House of Delegates that they reject the proposed constitution and by-law amendments which would increase the Board of Trustees from nine to eleven members; and,

Further, Be It Resolved, That they recommend that the House of Delegates recommend to the general meeting of the Society called for 9:00 o'clock p.m., September 30, that the Society reject the proposed changes in the Articles of Incorporation which would increase the Board of Trustees from nine to eleven members; and,

Further, Be It Resolved, That the Denver Medical Society recommends the continuation of the standing rule adopted at the 1952 annual session making the two immediate past presidents ex-officio members of the Board of Trustees.

Speaker Beebe referred all the reports and the first Denver Resolution to Reference Committees and announced the second Denver Resolution would be considered in connection with unfinished business already scheduled. The Speaker reminded all Delegates and all members of the Society about the privilege to present their views before any Reference Committee of the House.

Chairman Phelps of the Trustees then presented the following nominations for Certificates of Service and each was confirmed unanimously by the House on separate motions:

Edgar A. Elliff, M.D.

First of these is Edgar A. Elliff, M.D., of Sterling, Colorado. A busy physician in that growing North-eastern Colorado community, Dr. Elliff, at great personal sacrifice, has willingly absented himself from his home and his practice for long periods in order to serve the citizens of his district in the Senate of the Colorado General Assembly for the last three years. In so doing, he has emphasized the importance of good government and the responsibilities of our profession to the people in civic matters as well as in medical matters.

A former mayor of Sterling, Dr. Elliff has long been known for his general community service and for his constant willingness to serve in the public good. He has shown that physicians can also be leading citizens, and has set an example which should be an inspiration to all of us.

Your Trustees believe that Dr. Elliff's contribution to good citizenship and good government merit special recognition from the Colorado State Medical Society.

George W. Stiles, M.D., Ph.D.

Under the rules previously referred to, your Board of Trustees nominates Dr. George W. Stiles for a Certificate of Service to commemorate his more than forty years' devoted service as a public health leader for the benefit of mankind. Holder of the degrees of M.D. and Ph.D., George W. Stiles, now retired, can look back on a life of accomplishment in his beloved laboratories where his many works earned him the respect of his colleagues and the gratitude of our citizens.

He was director of laboratories for the U. S. Department of Agriculture in Denver for more than thirty-four years and only recently retired from five years as head of the State Department of Public Health laboratories. His research accomplishments were many, including his analysis of rabies in dogs. Over a period of many years his studies of animal diseases which could be transmitted to man contributed much to the protection of our people.

His accomplishments include important research in the fields of milk, water, poultry and animal disease diagnosis and his findings have been of invaluable assistance to the medical profession. In 1917 he established the first laboratory of animal industry in this region. He is the author of more than seventy-five scientific papers in his field and he is the holder of a number of honorary degrees.

Your Board believes Dr. Stiles has earned a special recognition from the Colorado State Medical Society for his accomplishments in public health.

Robert L. Perkin

Your Trustees' third nomination is Mr. Robert L. Perkin of Denver. We wish to honor a distinguished layman who has advanced the ideals of the medical profession and who has made a vital contribution to better health of our people through his enlightened and competent reporting of health and medical news and his writing of health articles.

Mr. Perkin is a science writer of unusual ability. He combines a thorough knowledge of his profession with thoughtfulness and consideration, with the result that his writings to and for the public achieve a brilliance and understanding of the highest level in journalism.

A graduate of the University of Colorado School of Journalism, Mr. Perkin has spent most of his fourteen working years on the Rocky Mountain News, except for a period of duty with the U. S. Navy during World War II. He is highly regarded by his profession both in Denver and in Colorado and the region. This fact was evidenced by the award for "an outstanding contribution to Colorado journalism" which came to him in 1951 from Sigma Delta Chi, professional journalism chapter at the University of Colorado.

Your Board feels that Mr. Perkin's accomplishments as a science writer have earned the respect of the people, the journalists and the physicians of our community and our state.

Annual reports of the Board of Councilors and the Board of Supervisors were presented as printed in the Handbook, and their being no discussion these were referred to the Reference Committees.

Report of the President

President Liggett addressed the House as follows:

Mr. Speaker, Officers of the Society, Members of the House of Delegates, and Members of the Colorado State Medical Society: Initially I want to thank the men who served on the Committees of the Society whose appointment was my responsibility at the outset of my term of office. The Committees have worked hard. The volume of business which this Society transacts, both internal and external, is enormous and it is growing greater each year. The wisdom and the thoroughness with which the Committees have functioned is a great credit to the profession. I am grateful to them for what they have done for the Society at my request.

It isn't easy to accept an assignment in an organization as big as this because of the amount of time which those Committees consume in the interests of medicine. I assure you that the activities of the Standing and Special Committees have been of immense importance over the years. You cannot all be intimate with the workings of those Committees, and there are a few whose importance I wish to emphasize.

After two years of close association with the work of the Society I am convinced that the Rural Health Committee is one of the most important in the organization. Colorado is still a rural state. The Society as a whole should be made more conscious of the fact that our duty is to promote better and ever-improving rural health facilities.

The Society has cooperated in an advisory way in civil defense in recent months. General civil defense activity, state-wide, has been confused, I am certain. No one seems to know what civil defense should mean, what proportions it should ultimately have. There is great concern about the need for preparedness, and that is an area in which the Colorado State Medical Society must devote a great deal of advice, counseling, and guidance, if the job is to be done properly and if we are to be ready for an emergency. The concept of defense has been widened in the last year to include all types of disasters. Certainly that is a valid and very proper enlargement of the scope of the problem.

Those of you from areas where you are closely connected with the Red Cross can do a great deal to disabuse the Red Cross people of the belief that Civil Defense intends to take over Red Cross functions. That question has been raised several times recently, and I am certain from the knowledge that I have that that is not the case.

There are many other committees. The fact that I have mentioned these two activities means that I am interested in them and their work, but there is no less credit due the others. Their work has been important and vital to our future and to our service to humanity.

The Executive Office has functioned very well throughout the year. We were able to stage an AMA Interim Session in Denver last year which has been a credit to all of us. The AMA is still extremely grateful for the manner in which it was managed, and that management was primarily the

responsibility of the Board of Trustees and the Executive Office. I must give special mention to that particular project which was so successful and such a satisfaction to all of us.

I have had a pleasant year in most respects. I have assiduously refrained from entering into Society politics, even in my own component Society, or over the state. Those of you who have had contact with me can, if you examine your own memories, recognize that fact. I have not tried to influence thinking about the Society's affairs in any sense. I have tried as best I could to be impartial, to be the guide and leader of the Society as the President should be, and I am fearful that I have been remiss in some directions in the assumption of my full responsibility.

I must, in all honesty, make some comment about the Supplemental Report of the Board of Trustees which deals with the Organization Study Committee. This is my personal comment and I alone am responsible for it. I must in all honesty disavow the implication that I was a party to its full production. I was not a party to any of the studies reported in it. I was not present at the meeting of the Committee as a whole, because at that time I was in Salt Lake City, and I am certain that there were other members whose names appear as being on that Committee who were not present at the meeting of the Committee as a whole. As a consequence, I must disavow its contents and implications.

Another matter of which I have personal knowledge is that the method of transmission of the document is at variance with the wishes of the Board of Trustees. The letter of transmittal says that the Board of Trustees is proud of the document, but I am certain that at the meeting of the Board of Trustees in which it was transmitted to the House of Delegates no such sentiment was expressed by the Board officially. Being a Supplement to the Report of the Board of Trustees, it is a confidential document. Its distribution, obviously, because of that fact, should have been limited only to those who properly should receive the Handbook of the House of Delegates. What distribution it has had I frankly cannot say, but I am certain and confident that it exceeded the limitations placed on confidential documents which are to come before the House of Delegates.

I feel that I, personally, have a deep responsibility in that I have knowledge of aspects of that report with which I disagree. I am certain that the good parts of it could very well have been executed by the Board of Trustees itself, without the necessity of publishing a document which to my mind has been hurtful and has resulted in harm to the Society. I stand ready to appear before the Reference Committee if asked, or before the House, if asked, to tell what I know about the formation of the report, its method of distribution, and the activities that went into its distribution.

The seriousness of its implications outweighs any personal feeling that I may have in reference to trying to protect individuals or myself from censure or criticism. I am certain that I would be far more subject to censure if I let it pass unchallenged.

President Liggett's report was referred to the Reference Committee on Board of Trustees and Executive Office.

Report of the President-Elect

President-elect Bonham addressed the House informally, calling attention to the problem of the veterans' medical care program which he would discuss in his presidential address (published in full, Rocky Mountain Medical Journal for November, 1953, Page 865 et seq.)

Report of the Treasurer

Treasurer W. A. Campbell addressed the House informally, explaining that he was serving out the unexpired term of the late Dr. George C. Shivers. At Dr. Campbell's request the House stood in silence in memory of Dr. Shivers. Dr. Campbell also recommended study of financial losses by the Rocky Mountain Medical Journal for the year just closed.

Other Annual Reports

Reports of the above officers were referred to the Reference Committee on Board of Trustees and Executive Office.

Dr. W. H. Halley supplemented the report of himself and Dr. George A. Unfug as delegates to the AMA by requesting the House to express its

opinion on the action of the delegates at the AMA special meeting in Washington last March and on the questions put to all state societies regarding future AMA attitudes for teaching in osteopathic schools. These questions were referred to the Reference Committee on Professional Relations.

Reports of the Foundation Advocate, the Executive Office staff, the Health Education Committee, the subcommittee on School Health, the Committee on Library and Medical Literature and the Committee on Medical Education and Hospitals were submitted as printed. Each was referred to an appropriate reference committee.

Chairman H. C. Hughes supplemented the printed report on Medical Service Plans stating that his committee had been asked, since publication of the Handbook, to make a study toward revision of the State Workmen's Compensation Insurance Fee Schedule. He recommends this be referred to the similar committee in the new administration.

Printed reports of the Medicolegal Committee and the Public Policy Committee were submitted and Dr. Kenneth Prescott presented a supplement on behalf of the Public Policy Committee requesting House of Delegates advice concerning requests of Colorado General Hospital and Denver General Hospital for membership in the Colorado Hospital Service (the Blue Cross Plan).

The following additional annual reports were submitted as printed and referred to reference committees without supplements: Subcommittee on Hospital-Professional Relations, Subcommittee on Publicity, Subcommittee on Legislation, Subcommittee on Nurses' Education, Subcommittee on Weekly Health Column, Committee on Scientific Work, Committee on Arrangements, General Committee on Public Health, Cancer Control Committee, Subcommittee on Rocky Mountain Cancer Conference, Committee on Chronic Disease, Committee on Crippled Children, Committee on Maternal and Child Health, Mental Hygiene Committee, Committee on Occupational Health, Committee on Rehabilitation, Committee on Rural Health and Health Councils, Committee on Sanitation, Committee on Tuberculosis Control, Committee on Venereal Disease Control, Committee on American Medical Education Foundation, Advisory Committee to the Woman's Auxiliary, Advisory Committee to U.M.W. Welfare and Retirement Fund, and the Automotive Safety Committee.

At the request of the Automotive Safety Committee Sgt. Leonard Johnson of the Denver Police Department addressed the House informally in support of the following resolution proposed by that Committee:

Resolution*

Whereas, The motor car deaths in the United States of America number between 35,000 and 40,000 annually and motor car injuries number about four million annually, and

Whereas, There seems little likelihood of any great reduction of motor accidents in the near future; and

Whereas, Studies by physicians and physicists have clearly shown that motor injuries and motor deaths can be strikingly reduced by the use of safety belts and safety shoulder straps; therefore be it

Resolved, That the Colorado State Medical Society will give all possible aid to those measures which will reduce the frightful mortality and injury rate resulting from the use of motor cars; and be it further

Resolved, That the Society hereby recommends to the motor car manufacturers of America that they equip all automobiles with safety belts to meet the specifications of the C.A.A. Technical Standard Order, T.S.O.-C 22 A, November 15, 1950, and further

*The above resolution was adopted. See page 974.

***A MERRY CHRISTMAS
and A HAPPY NEW YEAR!***

To All of Our Friends and Customers
We Extend Best Wishes for a
Happy Holiday Season.

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A Keleket X-Ray
Planned to Suit Your Individual
Requirements.

— ANOTHER GOOD WISH —

Accessories From Our Complete Line,
Which Includes the Finest Made.

— A THIRD GOOD WISH —

That You Get Acquainted With Our Service.
It Is Friendly, Prompt, Competent.

—From the House Service Is Building—

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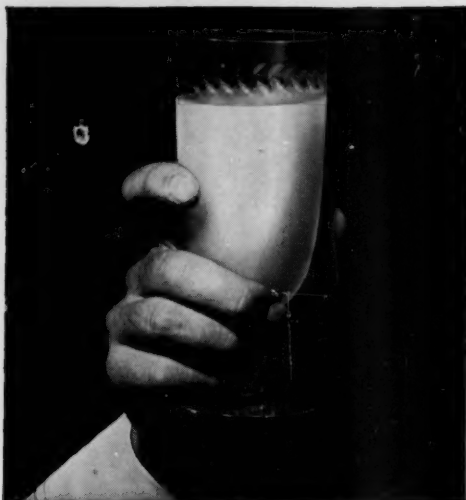
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1. Reich, C., and Mullins, M. G., Treatment of Refractory Nutritional Anemia with Gelatine. Bull. N. Y. Med. Coll. March 1953.

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The following additional reports were then submitted as printed and referred to reference committees: Committee on Blood Banks, Blue Shield Fee Schedule Advisory Committee, Committee on Emergency Medical Service, Committee on Military Affairs, Physicians' Placement Committee, Committee on Rocky Mountain Medical Conference, Special Committee on Series for Colorado Rancher and Farmer, Delegate to the Interprofessional Council, Representative to the Rocky Mountain Radio Council, and the Representatives to the Adult Education Council.

Chairman J. L. McDonald reported for the House of Delegates Interim Committee on Constitution and By-Laws and pointed out that the committee's report had been mimeographed and mailed not only to all delegates and alternates but all presidents and secretaries of component societies on June 20, 1953, constituting proposals for revision of both the Constitution and By-Laws of the Society.

Speaker Beebe referred the part of the Interim Committee's report proposing a revision of the By-Laws to the Reference Committee on Constitution and By-Laws, and ruled that the part of the committee's report consisting of amendments to the Constitution proposed one year ago will come before the House as unfinished business today. He then asked Executive Secretary Sethman if there was any other unfinished business on the desk and Mr. Sethman reported there was none except the Constitutional amendments.

Amendment of Constitution

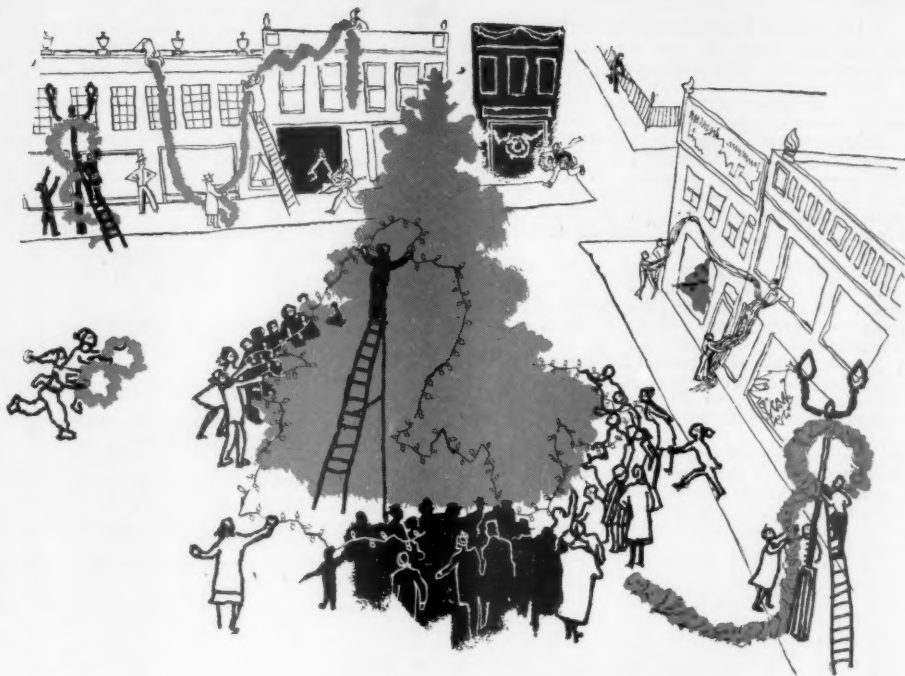
Dr. McDonald moved adoption of the amendment to Article IV of the Constitution relating to classification of members of the Society. The motion was seconded and after discussion and questions by several delegates was adopted without dissent and Speaker Beebe declared the Constitution so amended.*

Dr. McDonald moved adoption of the amendment to Article V, Section 2 of the Constitution limiting the voting privileges of the Speaker and the Vice Speaker of the House of Delegates. The motion was regularly seconded, adopted without dissent and Speaker Beebe declared the Constitution so amended.

Dr. McDonald moved adoption of the amendment to Article VII, Section 2 which would add the two immediate past presidents of the Society to the Board of Trustees, stating that he was doing so because the House had so directed last year, though he realized from reports received earlier today from the Board of Trustees and from the Denver Medical Society that it is probably not the desire of the House to pass the amendment.

The motion was lost for want of a second. Parliamentary questions concerning the status of the Constitutional revision in view of the loss of this motion were discussed by Drs. J. M. Perkins, G. R. Buck, S. P. Newman and Speaker Beebe, and by Secretary Sethman and General Counsel J. P. Nordlund. On recommendation of the General Counsel, Dr. McDonald then moved that the revised Constitution as now clarified and amended be adopted. The motion was seconded

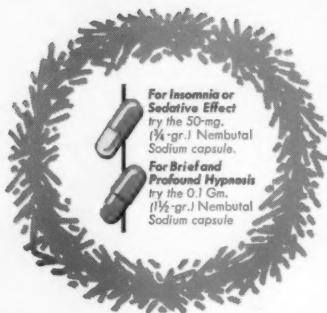
*This amendment and all other amendments to both the Constitution and By-Laws referred to in these minutes, appear in the booklet entitled "Articles of Incorporation, Constitution, By-Laws, and Standing Rules of the House of Delegates, 1953 Revision," published separately and distributed to officers of all component societies.



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by Dr. Buck and after further discussion was adopted without dissent. Speaker Beebe declared the Constitution so amended, clarified and adopted.

Election of Nominating Committee

As the first item of new business, Speaker Beebe called for nominations from the floor for the election of the Committee on Nominations to consist of seven delegates, no two of them from the same component society. The following nine delegates were nominated: Kenneth C. Sawyer, Denver; J. L. McDonald, El Paso; F. H. Zimmerman, Pueblo; Eugene Wiege, Weld; James F. Hoffman, Larimer; Lawrence D. Buchanan, Washington-Yuma; H. R. Bull, Mesa; George Balderston, Montrose, and C. O. Roberts, Boulder.

The Speaker appointed Drs. T. K. Mahon, W. H. Halley and W. A. Campbell as tellers for a secret ballot. Following the count, Speaker Beebe announced the following had been elected as the Nominating Committee:

J. L. McDonald, Kenneth C. Sawyer, F. H. Zimmerman, L. D. Buchanan, H. R. Bull, James F. Hoffman and Eugene Wiege. This Nominating Committee later selected Dr. Hoffman as its Chairman.

Dr. Eugene Wiege, due to the illness of Dr. T. E. Heinz, moved that the House seat Dr. Donn J. Barber as delegate and Dr. Roy A. L. Swanson as alternate for that position representing Weld County. The motion was seconded and carried without dissent.

Dr. Edgar Durbin asked the House to consider inviting the American Heart Association to hold its 1956 Convention in Denver. The request was referred to the Reference Committee on Scientific Work.

Proposal For Open Meeting

Vice Speaker Ley requested the House to consider throwing its second meeting open to all persons registered at the Annual Session as was done one year ago at Estes Park, and to consider making this an annual custom. The motion was made and seconded. Following discussion and amendment of the motion the House voted to open its second meeting as indicated this year and to authorize the Board of Trustees to determine from year to year whether or not this shall be done annually.

Mr. Watson, a senior medical student at the University of Colorado representing the Colorado Chapter of the Student AMA, was introduced and greeted the House briefly.

The House then adjourned.

SECOND MEETING—Wednesday, Sept. 30, 1953

Speaker Beebe called the House to order at 8:00 p.m. in the Lincoln Room after informally explaining to all persons present the nature of this open meeting of the House.

Chairman Hendryson of the Credentials Committee recommended that Dr. Edward G. Merritt be seated as delegate from the San Juan Basin Medical Society.

The roll call disclosed fifty-five accredited members of the House present, more than a quorum, and upon motion the above report of the Credentials Committee was then adopted.

Minutes of the first meeting of the House were read and were approved as read.

Honorary Member: Harry A. Smith

Chairman Leo W. Lloyd submitted a supplemental report of the Board of Councilors as follows:

Your Board of Councilors, which held its first meeting in Annual Session yesterday afternoon, has approved the nomination of Harry Austin Smith, M.D., of Whittier, California, for Honorary Membership in the Colorado State Medical Society. The nomination was submitted to us by the Board of Trustees.

Dr. Smith was for many years a leading citizen and estimable practitioner of ophthalmology and otolaryngology in Delta, Colorado. He served with distinction as President of the Colorado State Medical Society for the Society's 1921-22 year. For family health reasons he moved to Whittier, California, in 1928, and soon thereafter resumed practice of ophthalmology in that city where he has ever since been a leading citizen and a highly respected physician.

He transferred his membership from our Society to the California Medical Association, as required by the Constitution and By-Laws of the American Medical Association. He is the only past-president of our Society residing permanently outside of the State of Colorado.

Your Board of Councilors therefore recommends that the House so elect Dr. Smith.

On motion regularly seconded and passed unanimously, Doctor Smith was elected an honorary member of the Society.

By-Law Amendment Proposed

Chairman Lloyd submitted another supplemental report for the Board of Councilors as follows:

The Board of Councilors, because of situations which have arisen, and may arise again in the future, indicating a need for closer supervision of applicants for membership in this Society who have previously been expelled from this or any other State Medical Society, has had our attorney draw up a proposed amendment to the By-Laws which we wish the House to consider at this Annual Session.



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¹Evans, R. R., and Rackemann, F. M.: *A.M.A. Arch. Int. Med.* 90:96-127, July 1952.

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As the By-Laws require, the written amendment is appended as a Supplement which I will read to you:

Add a subsection "c" under Section 7, Chapter XI, of the revised By-Laws to read as follows:

"c. In the event that the information returned from the Society's Executive Office discloses, or in the event it is otherwise known, that the applicant at any time shall have been expelled from membership in this Society, or any other constituent of the American Medical Association, the Component Society shall defer action on the application and shall submit the application to the Board of Councilors, with such recommendations, if any, as the Component Society deems warranted, for review by the Board of Councilors. The Board may approve, disapprove, or may suspend consideration of this application. Unless and until the Board shall have approved the applicant's eligibility for membership and shall have so notified the Secretary of the Component Society, no further action may be taken by the Component Society on this application."

Chairman Lloyd reported verbally that the Board of Councilors and all available former members of that Board and their wives had just concluded a testimonial dinner in honor of Dr. Ella A. Mead of Greeley, who has served continuously as a member of the Board of Councilors since October 1, 1925.

First Report of Reference Committee on Board of Trustees and Executive Office

Chairman Edgar A. Elliff of the Committee presented the following preliminary report, which was adopted section by section and as a whole:

Your Reference Committee on Board of Trustees and Executive Office makes the following partial report.

(a) The report as printed on page 6 of the Handbook is still under consideration by the Committee and it will report on that at a later date.

(b) Your Committee recommends adoption of the Supplemental Report of the Board of Trustees embracing the budget for 1953-1954 fiscal year, as printed on Page 11 of the Handbook.

(c) Your Committee recommends adoption of the Report of the Foundation Advocate.

(d) Your Committee recommends adoption of the Report of the Executive Office.

(e) Your Committee recommends adoption of the Report of the Advisory Committee to the Woman's Auxiliary. We wish also to compliment the Woman's Auxiliary on their excellent work and their great accomplishments of the past year.

Report of the Reference Committee on Scientific Work

Chairman James Mezen of the Committee presented the following report which was adopted section by section and as a whole:

Your Reference Committee approves the report of the Committee on Library and Medical Literature and recommends its adoption as published. The Committee would like to call the attention of the State Society members to the fact that the books and literature are available for use and may be obtained by mail upon request of the library.

Your Reference Committee accepts the report of the Committee on Medical Education and Hospitals as a statement of fact, but we suggest that the incoming Committee take a more active part in the duties of this Committee.

Your Reference Committee moves adoption of the report of the Committee on Scientific Work as published. The Committee notes that there has been a decline in the number of scientific exhibits by private practitioners and it is suggested that some

stimulus be provided by awarding an appropriate certificate for the best exhibit and that the certificate be posted on the exhibit on the morning of the day of the banquet and that the award be announced at the annual banquet as has been the custom in the past. The Committee should be commended on the fact that the program at the Mid-winter Clinics produced a net income for the Society. We wish to commend the Committee for the excellence of the scientific programs both at the Mid-winter Clinics and at the present Annual Session.

Your Reference Committee moves adoption of the report of the Committee on Arrangements as published. We wish to commend the Committee for the very enjoyable stag dinner and party and the afternoon entertainment and sports. We recommend that an appropriate letter of thanks be sent to Mr. Julius Berbert from the President of the Society. We further recommend that special thanks be given to the Woman's Auxiliary for their fine efforts in arranging our annual banquet, and that an appropriate letter of thanks be written.

Your Reference Committee moves adoption of the report of the Subcommittee on Rocky Mountain Cancer Conference as published. We wish to commend the Committee for the excellent scientific program provided and give appropriate recognition to the Colorado Division of the American Cancer Society for making this program possible. We recommend that an appropriate letter of thanks be sent to the Colorado Division of the American Cancer Society for its continued support of professional education in Colorado.

Your Reference Committee recommends that the House of Delegates favor the possibility of The American Heart Association Annual Scientific Session being held in Denver in the Fall of 1956, and, subject to the cooperation of the Colorado Society of Internal Medicine and the Denver Heart Group, an invitation be sent to the American Heart Association urging completion of arrangements.

Report of the Reference Committee on Public Relations

Chairman W. N. Baker presented on behalf of the Reference Committee on Public Relations the following report which was adopted section by section and as a whole:

Your Reference Committee on Public Relations reports approval of the reports of the following committees as printed:

The Advisory Committee to U.M.W. Welfare and Retirement Fund; Special Committee on Series for Colorado Rancher and Farmer; Representatives to the Rocky Mountain Radio Council; Representatives to Adult Education Council, and the Committee on Blood Banks.

Your Reference Committee approves the report of the Committee on Health Education as printed and strongly urges that each component society appoint a Health Advisor from among their members as soon as possible.

Your Committee approves the report of the subcommittee on School Health as printed and wishes to particularly emphasize its belief that examinations and immunizations of children ideally must be done wherever possible and whenever possible by the private physician in the private physician's office.

Your Committee approves the report of the Committee on Medical Service Plans and urges that the new Committee without delay contact the Industrial Commission of Colorado in an effort to revise the Workman's Compensation Fee Schedule.

The Reference Committee on Public Relations is unable to give an opinion to the House of Delegates on the report of the Public Policy Committee in paragraph 7, page 23, as printed in the Handbook, relative to Senior Medical students care of indigent patients in their homes, because of the legal complications that might arise.

With reference to paragraph 4, page 24, of the printed report of the Public Policy Committee, your Committee advises against the reopening of con-

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sideration of the establishment of centers at the Medical School and the Denver Children's Hospital for congenital heart patients.

The Committee approves the Public Policy Committee's stand on routine miniature chest x-rays being made on all admissions to general hospitals as being idealistic and concur with this body that this non-essential procedure would increase the cost of hospital care.

The Committee further wishes to question the necessity of duplication of routine laboratory work such as blood and urines that is done by hospitals having been previously done in the physician's office or at a private laboratory before entering the hospital, thus increasing the cost of medical care. Study of this problem may lead to lessening the cost of medical care.

Your Committee therefore disapproves that section of the report of the subcommittee on Hospital-Professional Relations dealing with this matter.

The matter concerning Veterans medical care considered by the Committee on Public Policy will be presented in the form of a resolution at the end of this report.

The report of the subcommittee on Publicity is approved as printed. Your Committee wishes to add that every effort should be made to assist in the publication of medical information in a proper manner. We strongly wish to recommend that all doctors of medicine, particularly new members of the Society, be indoctrinated as to what constitutes ethical publicity, advising that clearance through the Committee on Publicity or any other body constituted for this purpose be obtained prior to its release for public consumption.

Your Committee approves the report of the subcommittee on Legislation and especially wishes to commend Dr. Ralph M. Stuck of Englewood, who has represented his district for the past three years, for his untiring efforts in promoting legislation beneficial to the health of the people of Colorado.

The Committee approves the Report of the subcommittee on Weekly Health Column and wishes to commend this committee for its excellent work. We heartily endorse the continuance of this committee and its good work.

The Committee approves the report of the Automotive Safety Committee as printed and endorses its Resolution, wishing to add only that if other safety devices are devised they be properly endorsed also.

The Committee approves the report of the Blue Shield Fee Schedule Advisory Committee as printed in the Handbook and suggests that the subcommittee soon to be appointed work diligently in the program already underway.

Your Committee has considered the Supplemental Report of the Public Policy Committee and as a matter of principle, your Committee recommends that this House of Delegates record its firm opposition to the participation of fully tax supported institutions in non-profit hospital and medical insurance plans. Your Committee approves the remainder of the Supplemental Report of the Public Policy Committee.

Chairman W. N. Baker presented on behalf of the Reference Committee on Public Relations the following resolution which was adopted unanimously:

Resolution: Veterans' Non-Service Connected Disabilities

Whereas, The medical profession, of Colorado and of all America, has always supported and will continue to support the principle that veterans of the Armed Forces who have physical or mental handicaps which were either incurred during military service or aggravated by military service are entitled to the finest medical care and hospitalization available, through the Veterans Administration; and,

Whereas, The House of Delegates of the American Medical Association has made lengthy and exhaustive studies of the economic, social, political and medical implications of the expanding Veterans Administration program of medical care and hospitalization benefits for veterans of the Armed Forces with non-service-connected disabilities; and,

Whereas, Following such studies and following conferences between the American Medical Association and appropriate representatives of the Veterans Administration, the national organizations of veterans, and other interested groups, the House of Delegates of the American Medical Association has become convinced that new legislation completely changing government policy toward the federal care of veterans with non-service-connected disabilities is necessary to protect this nation from a system of socialized medicine fully as disastrous as



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1. High public acceptance as to flavor and palatability—billions eaten annually.
2. One of the best of the “protective” foods with a well-rounded supply of vitamins and minerals.
3. Low sodium—very little fat—no cholesterol.
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10. Useful in bland and low-residue diets.
11. Mildly laxative.
12. May be used in the management of both diarrhea and constipation.
13. Can be used in reducing diets.
14. Can be used in high-calorie diets.
15. Useful in the dietary management of celiac disease.
16. Useful in the dietary management of idiopathic non-tropical sprue.
17. Useful in the management of diabetic diets.
18. Valuable in many allergy diets.
19. Belongs among foods useful in certain acute intestinal infections.
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the system proposed and rejected two years ago; and

Whereas, The House of Delegates of the American Medical Association in June, 1953, adopted a permanent policy in this connection, the essential clauses of which state that the American Medical Association "recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

- (a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated; and
- (b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service-connected origin, who are unable to defray the expenses of necessary hospitalization."

And "that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service-connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs."

Now, Therefore, Be It Resolved, by the House of Delegates of the Colorado State Medical Society in 83rd Annual Session: That the Colorado State Medical Society hereby endorses the above quoted policy of the American Medical Association, without reservation, and pledges the resources of this Society to assist in carrying out said policy.

Report of the Reference Committee on Public Health

Chairman Franklin J. McDonald of the Committee submitted the following report which was adopted section by section and as a whole:

Your Reference Committee approves the report of the General Committee on Public Health as published.

Your Reference Committee approves the report of the Cancer Control Committee as published. Your Reference Committee commends this Committee and

recommends they continue a study of convalescent facilities for care of cancer patients. Your Committee further recommends that education relative to cancer be continued and extended.

Your Reference Committee approves the report of the Committee on Chronic Disease as published.

Your Reference Committee approves the report of the Committee on Crippled Children as published, with this qualification: the term "qualified orthopedist" as used in Paragraph 1 of the report shall mean a surgeon approved by his hospital staff as being competent to practice orthopedics.

Your Reference Committee approves the report of the Committee on Maternal and Child Health as published, strongly endorsing the program of fluoridation of community water supplies, where indicated, in Colorado.

Your Reference Committee approves the report of the Mental Hygiene Committee as published. Your Reference Committee further recommends that the title of this Committee be changed to "The Committee on Mental Health." This nomenclature coincides with the American Medical Association designation of a similar committee.

Your Reference Committee approves the first three and the fifth paragraphs of the report of the Committee on Occupational Health as published. Your Reference Committee disapproves that portion of the report embodied in Paragraph 4. Your Reference Committee further strongly endorses the portion of the law embodied in Section XVII, Paragraph "m" of the Medical Practice Act of 1951, which reads as follows:

"Practicing medicine as the partner, agent or employee of, or in joint adventure with, any person who does not hold a license to practice medicine within this state, or practicing medicine as an employee of, or in joint adventure with, any partnership, association or corporation; provided, however, any licensee holding a license to practice medicine in this state may accept employment from any person, partnership, association, or corporation to examine and treat the employees of such person, partnership, association or corporation; . . . " (Indulgence in this type of practice constitutes unprofessional conduct under the law.)

Your Reference Committee recommends approval of the report of the Committee on Rehabilitation as published.

Your Reference Committee approves and commends the report of the Committee on Rural Health

and Health Councils as published, and recommends continuation of this highly important phase of State Society activities.

Your Reference Committee approves the report of the Committee on Sanitation as published and strongly urges the Society to continue to attempt to secure adequate legislation relative to stream pollution.

Your Reference Committee approves the report of the Committee on Tuberculosis Control as published.

Your Reference Committee approves the report of the Committee on Venereal Disease Control as published.

Report of Reference Committee on Professional Relations

Chairman James F. Hoffman presented the following report for the Committee, parts of which were adopted and part of which was referred to the Reference Committee for further consideration as indicated below:

Your Reference Committee approves the report of the Board of Councilors as printed. (Adopted)

Your Reference Committee approves the report of the Board of Supervisors as printed, and extends to them a vote of commendation for their excellent work during the past year. (Adopted)

With regard to that section of the Supplemental Report of the Board of Trustees referred to this Reference Committee, the Committee did not feel that there was sufficient information available to it to decide at this time whether or not osteopathy should be considered a "cultist" healing, and felt that this question could not therefore be answered. With regard to the second question, in view of the fact that the objectives of the American Medical Association are to improve undergraduate and post-graduate education, doctors of medicine should be allowed to teach in osteopathic schools. With regard to the third question, your Reference Committee feels that the relations of doctors of medicine to doctors of osteopathy should be a matter of determination by the several state associations.

(The above paragraph of the report was referred to the Reference Committee for further consideration, following discussion by Drs. J. B. Farley, William E. Hay, James M. Perkins, Terry J. Gromer, Edgar Durbin, Thomas K. Mahan, Eugene Wiese, Alex D. Waroshill, Treasurer William A. Campbell and Chairman Hoffman of the Reference Committee. Chairman Hoffman then presented additional parts of the Reference Committee Report.)

Your Reference Committee approves the report of the Medicolegal Committee as printed, and approves the Resolution from the Pueblo County Medical Society, (presented to the Reference Committee) instructing its delegates to appear before the House of Delegates of the Colorado State Medical Society and request that the Delegates to the American Medical Association do all in their power to impress on the American Medical Association that its individual members are much concerned about the malpractice insurance rates, and that the American Medical Association Delegates from Colorado be instructed to exert all efforts towards bringing this serious matter to the attention of the House of Delegates of the American Medical Association; further, that they introduce a resolution and do all in their power to pass such a resolution requiring that the American Medical Association thoroughly investigate the possibility of lowering malpractice insurance rates. (Adopted)

Your Reference Committee approves the report of the subcommittee on Nurses Education with the exception of the last paragraph, which we recommend be deleted. Your Reference Committee also believes that this Committee is a very important one and urges that the President use considerable judgment and care in appointing members of this Committee, and that this Committee be instructed to be as active as possible in establishing good relations with nursing groups. (Adopted)

Your Reference Committee approves the report of the American Medical Education Foundation Committee as printed and suggests that it would be desirable for the Committee to again educate the doctors in the desirability for contributing to this Foundation, and to report on what has been achieved by the contributions made to date. (Adopted)

Your Reference Committee approves the report of the Physician's Placement Committee as printed and suggests that it be continued and that there be

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"It's not for me," she answers, "it's to remind you, and everybody else who asks what it's for, to contribute to the Woman's Club Library Fund. We need \$200 and we figured we'd get more help if we could get people to ask us about it."

Well, as it turned out, the red ribbon worked just fine. The ladies are having the library all fixed up—and there's enough money for some new books, too.

From where I sit, it would be a fine thing if we had some sort of private reminder when we forget the rights of others. Like when we start telling them how to practice a profession or what to choose for a beverage. I like a travel book and a temperate glass of beer—while you may prefer a cup of tea with a historical novel. But let's not "put the finger" on one another.

Joe Marsh

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close cooperation between this Committee and the Rural Health Committee. (Adopted)

Your Reference Committee approves the report of the Committee on Rocky Mountain Medical Conference as printed. (Adopted)

Your Reference Committee has reviewed the report of the Delegate to the Interprofessional Council. In view of the fact that for several years no meetings have been held by the Colorado Interprofessional Council, your Reference Committee suggests that it be abandoned. (Adopted)

On motion of Chairman Hoffman, seconded and carried without dissent, the above report was adopted as a whole, as amended by referral of one paragraph.

Revision of By-Laws

Report of the Reference Committee on Constitution and By-Laws

Chairman William C. Service of the Committee submitted the following report which was adopted section by section and as a whole without dissent:

Your Reference Committee studied the report of the subcommittee of the Board of Trustees to study society committees which met jointly with the Interim Committee on Constitution and By-Laws. We approve this report as published in the supplemental report of the Board of Trustees to the House of Delegates as published on Page 1 of the Report.

Your Reference Committee considered the Supplement to the Report of the Interim Committee on Constitution and By-Laws. This report concerned both Constitution and By-Laws and will be taken up part by part. The Constitutional changes were adopted at the opening session of the House and, therefore, require no action by your Reference Com-

*The above refers to a constitutional amendment only proposed (not acted upon) at this Annual Session by the Interim Committee on Constitution and By-Laws, for final action at the 1954 Annual Session. The proposal will be officially referred to the component societies as required by the Constitution.

mittee. However, your Committee does wish to point out, on advice of counsel, that in Article II, Line 6, the comma should be changed to a semi-colon.

Your Reference Committee considered Article X of the Constitution on Referendum.* This article is concerned with removing the power of a minority to delay functioning of the Society by demanding a referendum by mail. This article is referred to the House without recommendation. It will be submitted for action as unfinished business at the 1954 Annual Session.

The next portions of this report concern the By-Law changes recommended in the Supplement to the Report of the Interim Committee on Constitution and By-Laws.

Your Reference Committee has corrected any typographical errors that were found and also has made minor changes in wording for the purposes of clarification. Only those changes in wording which change the meaning or intent of the By-Laws will be considered individually in the rest of this report.

In Chapter I, Section 5, Line 9, the word "active" is deleted. In Line 20 and 21 the words "active or associate" are deleted as superfluous words.

No changes were made in Chapter II. No changes were made in Chapter III. No changes were made in Chapter IV.

In Chapter V, Section 5, the phrase "shall supply copies thereof to the secretaries of all component societies" (Lines 3, 4, and 5) is deleted.

In Chapter V, Section 10, Line 3, the word "accredited" is inserted before the word members so that the sentence reads as follows: "The House of Delegates, by a two-thirds vote of all accredited members of the House registered at that Annual Session or special meeting, etc."

No changes were made in Chapter VI. No changes were made in Chapter VII.

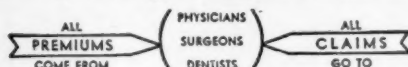
In Chapter VIII, Section 4, Lines 3, 4, and 5, the phrase "the Constitutional Secretary who shall be its Chairman" is deleted and the word "six" in Line 5 is changed to "seven" making the sentence read as follows: "The Committee on Constitution, By-Laws and Credentials shall consist of seven delegates . . ." etc.

In Chapter VIII, Section 12, Line 13, the words "and regulate" are added at the end of the line. The sentence then reads as follows: "To this end the Committee shall coordinate and regulate those ac-

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Anesthetic in Hospital.....	10.00	20.00	30.00	40.00
X-Ray in Hospital.....	10.00	20.00	30.00	40.00
Medicines in Hospital.....	10.00	20.00	30.00	40.00
Ambulance to or from Hospital.....	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19.....	1.50	3.00	4.50	6.00
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tivities of other standing and special committees . . . etc.

In Chapter VIII, Section 14, entitled "Scientific Programs," the letter "s" in the word "programs" is deleted from the title of the committee in this section and wherever else it so appears in these By-Laws.

No changes were made in Chapter IX.

Your Reference Committee made no changes in Chapter X. However, it recommends that the revision called for in Section 7 relating to part-year dues not become effective until December 1, 1953.

No changes were made in Chapter XI.

Mr. Speaker, I move the adoption of the By-Laws as a whole with the above changes. (The motion was seconded and adopted without dissent.)

Your Reference Committee has studied the report of the Interim Committee on Constitution and By-Laws as published and we recommend adoption of this report except where it is in variance with the Supplemental Report of the Committee on Constitution and By-Laws as just adopted.

Your Reference Committee has considered the paragraph of the Supplemental Report of the Board of Trustees to the House of Delegates that was referred to it, relating to the increasing of the membership of the Board from nine to eleven members. Your House of Delegates, by its action at its opening session, failed to pass the Constitutional Amendment increasing the Board to eleven members. This same question, as it relates to proposed changes to the Articles of Incorporation, will be considered at a general meeting of the Society tonight. Your Reference Committee has studied the proposed amendments to the Articles of Incorporation and recommends to the Society that it adopt these amendments to the Articles of Incorporation with the exception that the word "eleven" be changed to "nine" in Line 9 of the second proposed amendment. By so doing, this will leave the Board of Trustees with a membership of nine.

Your Reference Committee would especially like to commend the Interim Committee on Constitution and By-Laws and all other committees and individuals who participated in the careful and detailed work in the preparation of the revision of the Constitution and By-Laws.

Speaker Beebe declared the By-Laws of the Society so amended, revised and adopted.

Reference Committee on Military Affairs and Miscellaneous Business

Chairman H. R. Bull of the Committee presented the following report which was adopted without dissent:

Your Reference Committee on Military Affairs and Miscellaneous Business for the Colorado State Medical Society met and discussed the work of the Committee on Military Affairs and recommends acceptance of the report. The report of the Committee on Emergency Medical Service as it appears in the Handbook was reviewed by the Reference Committee and its adoption by the House of Delegates is also recommended.

There was no unfinished business. Under new business Dr. James M. Perkins introduced Col. Richard Eanes, Chief Medical Officer of the Selective Service System, and Mr. Sethman in-

troduced Mr. Leo E. Brown, Public Relations Director of the American Medical Association. Both guests were greeted with applause. Speaker Beebe announced that Mr. Brown, in addition to appearing on the General Assembly Program of the Society, would address the House of Delegates tomorrow morning on confidential matters, in executive session.

Dr. Wiley Jones, past Speaker of the House, requested clarification of the status of the suggested executive session of the House and executive sessions being conducted by the Reference Committee on Board of Trustees and Executive Office. The question of reasons for executive sessions was discussed by the Speaker and Chairman Elliff of the Reference Committee and others but no action was taken.

The House then adjourned.

THIRD MEETING—Thursday, October 1, 1953

Speaker Beebe called the House to order at 8:30 a.m. in the Colorado Room. Chairman Hendryson of the Credentials Committee moved the seating of Alternate R. H. Smith for Delegate J. L. McDonald of El Paso County. Roll call disclosed fifty-four delegates present, more than a quorum, whereupon Dr. Hendryson's recommendation was adopted. (Dr. J. L. McDonald was re-seated for El Paso County upon re-entering the room.)

Minutes of the second meeting of the House were read and approved as read.

Report of the Nominating Committee

Chairman James F. Hoffman of the Committee on Nominations submitted the following report which, not being subject to adoption, was received and placed on file.

Your Committee on Nominations respectfully offers the following slate of nominations for positions to be filled by election at this 83rd Annual Session:

For President-Elect, Samuel P. Newman, of Denver.

For Vice President, William A. Campbell, of Colorado Springs.

For Treasurer, three-year term, Frank I. Nicks, of Colorado Springs.

For Trustee, three-year term, C. Walter Metz, of Denver.

For Councilor, District No. 4, three-year term, Ward C. Fenton, of Rocky Ford.

For Councilor, District No. 5, three-year term, Scott A. Gale, of Pueblo.



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For Councilor, District No. 6, three-year term, Herman W. Roth, of Monte Vista.

For Members of the Board of Supervisors, each for a two-year term, six to be elected, David W. McCarty, of Longmont; Duane F. Hartshorn, of Fort Collins; Geno Saccomano, of Grand Junction; Kenneth H. Beebe, of Sterling; Albert P. Ley, of Monte Vista, and William N. Baker, of Pueblo.

For Delegate to the AMA, two-year term, George A. Unfug, of Pueblo.

For Alternate-Delegate to the AMA, two-year term, E. H. Munro, of Grand Junction.

For Foundation Advocate, Walter W. King, of Denver.

For Speaker of the House of Delegates, Eugene B. Ley, of Pueblo.

For Vice Speaker of the House of Delegates, John A. Weaver, Jr., of Greeley.

For the place of the 86th Annual Session to be held in 1956, the Committee recommends Estes Park. However, if the Board of Trustees finds at that time that the facilities are inadequate, we recommend that the meeting be held in Colorado Springs.

There was no unfinished business. Under new business Speaker Beebe reminded the House of the recommendation for an executive session at this time, and asked if there were objections to the House going into executive session. There being none, he declared the House in executive session and appointed Dr. L. R. Safarik as sergeant-at-arms. In executive session the House received a confidential report but took no action.

On resumption of open session Vice Speaker Ley reminded delegates of the limitation placed by the By-Laws upon introduction of new business at tomorrow's meeting of the House and urged that any further new business be presented at this time. There was none, whereupon the House adjourned.

FINAL MEETING—Friday, October 2, 1953

Speaker Beebe called the House to order at 8:30 a.m. in the Colorado Room. There were no further reports from the Credentials Committee and the roll call disclosed fifty-nine accredited delegates present, more than a quorum.

On motion of the Pueblo County Delegation, Dr. Carl W. Swartz, alternate, was seated in the absence of his delegate, F. H. Zimmerman.

Minutes of the third meeting of the House were read and approved as read.

Election of Officers

By direction of Speaker Beebe, Executive Secretary Sethman reread the report of the Committee on Nominations as submitted at the third meeting of the House.*

Speaker Beebe called for further nominations for the office of President-Elect. There being none, the Speaker declared the nominations

closed and entertained a motion directing the Secretary to cast the unanimous ballot of the House for Dr. Samuel P. Newman, of Denver, as President-Elect of the Society. The motion was made, seconded and carried unanimously. Speaker Beebe declared Dr. Newman elected and appointed Past Presidents John S. Bouslog and Ervin A. Hinds to escort Dr. Newman to the platform. Dr. Newman acknowledged the applause of the House and thanked the delegates for the honor bestowed upon him.

Speaker Beebe asked if there were any further nominations for the office of Vice President. Dr. H. E. McClure of Prowers County Medical Society nominated Dr. Lawrence D. Buchanan for Vice President. The nomination was seconded by Dr. H. C. Hughes of Denver. There being no additional nominations, the Speaker closed the nominations and appointed Drs. Bouslog, Hinds and T. K. Mahan as tellers to conduct a secret ballot. The tellers reported the ballot to Speaker Beebe who announced that Dr. Buchanan had been elected Vice President.

Speaker Beebe then proceeded by independent actions in each instance to conduct the election of all other nominees submitted to the House by the Nominating Committee and, there being no further nominations from the floor, the House elected those nominees in each instance unanimously.

The House, pursuant to the Nominating Committee report, selected Estes Park for the 86th Meeting, to be held in 1956, with the provision that if the Board of Trustees finds the facilities inadequate, that year's Annual Session would be held at Colorado Springs.

Proposal to Amend Constitution

With Vice Speaker Ley in the Chair, Speaker Beebe addressed the House as follows:

I want to thank the Delegates individually for all the effort they have put in on various serious problems that have come before us.

I would like to suggest to next year's House of Delegates that it consider an amendment to the Constitution to make the term of Speaker three years rather than one. In one year you have hardly learned all of the idiosyncrasies of the office. By the end of three years maybe it would become more enjoyable. For that reason I would make the suggestion that they consider making the Speaker and Vice Speakerships three years, the same as members of the Board of Trustees. In the AMA the speakership lasts for quite a while, as long as they can get along with him, almost. The same situation exists in the houses of Congress and in the local assembly. Therefore, as my parting shot I make that recommendation.

In response to a question by the Vice Speaker as to whether he wished to offer this suggestion formally as an amendment to the Constitution, Speaker Beebe stated his opinion that as a non-voting member of the House he could not do so. Dr. John H. Amessee then formally offered Dr. Beebe's suggestion as a Constitutional Amendment, to lie on the table for one year.*

*To be submitted officially to the component societies as required by the Constitution.

*See Report beginning on Page 979.

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Second Report of the Reference Committee on Board of Trustees and Executive Office

Chairman Elliff reported for the Committee as follows:

I move we approve the new State Budget and all other reports of the Board of Trustees and Executive Office, except that part of the report of the Board of Trustees relating to the Organization Study Committee.

Doctor Elliff's motion was seconded and carried without dissent, and he then addressed the House as follows:

Your Committee has been very much impressed by the sincerity and cooperation of members appearing before it, in trying to straighten out this slight controversy that has come up before the State Society. Not one member who appeared before that Committee left a bad impression. I think probably there are some misunderstandings, and I do not think that a discussion of them should be entered into at the state level. With this in mind, I hope you will go along with the recommendation of the Committee, as we have tried our best to keep this thing quieted down and get it straightened out in an efficient and quiet manner for the benefit of the State Society as a whole.

Third Report of the Reference Committee on Board of Trustees and Executive Office

Chairman Elliff of the Reference Committee then presented the following special report which was adopted as a whole without dissent:

Your Reference Committee has carefully studied the Supplemental Report of the Board of Trustees to the House of Delegates. In addition to this your Reference Committee has sought the advice and opinion of many members of our Society including the President, the President-Elect, the Chairman of the Board of Trustees, the Constitutional Secretary, the Executive Secretary, the Editor of the Rocky Mountain Medical Journal, several past presidents,

and most of the members of the Board of Trustees. In the interest of preserving harmony in our Society and with a view to preventing further friction between the members of our Society, your Reference Committee has conducted all of its hearings in Executive Session.

Your Reference Committee feels that this report is too repetitious—too verbose—too general—and too slanted with opinion and too poorly organized to be approved. On the other hand, the report represents so much hard work and contains so much that is valuable and good that the Committee feels that it cannot be rejected. Your Reference Committee therefore recommends to the House of Delegates that this report be received and re-referred back to the Board of Trustees with the following recommendations:

1. That the Board of Trustees put its own house in order and do everything possible to eliminate the discord now existing between its own members.

2. That the Board of Trustees take such steps as may be necessary to create harmonious working conditions in our state office and a more friendly and cooperative relationship between all the members of the Executive Office Staff.

3. That a definite policy of liaison between the Board of Trustees and the Executive Office be established, as directed by the Constitution and By-Laws. In this connection it is further recommended that definite lines of authority be established in the Executive Office of the Society with the Executive Secretary definitely in charge of all matters pertaining to the administration of that office.

4. That the newly organized Board of Trustees discharge the Committee which prepared this report with thanks for the time and effort which the members of the Committee have given in behalf of our Society.

5. That the Board of Trustees be charged with the responsibility of appointing at the earliest possible time a new committee for the purpose of studying and evaluating the structure and the function of our Society in all fields of operation. That this new study committee be appointed by the Board of Trustees in consultation with the President.

6. That the committee thus appointed shall be made up of nine (9) experienced members of our Society.

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7. That the Chairman of this study committee shall also be a member of the Board of Trustees and that the other eight (8) members be chosen with a view to obtaining representation from the various geographical areas of the state.

8. That the Board of Trustees shall be further charged with the responsibility of selecting men to serve on this study committee who are familiar with the structures and functions of our Society—who are temperamentally fitted for the job, and who can be relied upon to carry on the investigative and research work of the committee in an objective and dispassionate manner.

9. That the Board of Trustees also be charged with the responsibility of presenting the findings and recommendations of its study committee to the House of Delegates at its next Annual Session.

On motion of Chairman Elliff, seconded and passed without dissent, all reports of the Reference Committee on Board of Trustees and Executive Office were then adopted as a whole.

Dr. C. C. Wiley proposed the following motion:

As a member of the Reference Committee on Board of Trustees and Executive Office, I move that the Board of Trustees be instructed to notify all persons known to have received a copy of this Supplemental Report that it is not final and has been re-referred for further investigation.

The motion was seconded by several and in discussion AMA Delegate Halley proposed that the House owed a great vote of thanks and appreciation to this Reference Committee. Vice Speaker Ley ruled a motion was already before the House, there was no further discussion and Dr. Wiley's motion passed without dissent. Dr. Buck then moved that the House especially commend the Reference Committee on Board of Trustees and Executive Office. The motion was seconded by several and carried unanimously.

Second Report of the Reference Committee on Professional Relations

Chairman James M. Hoffman presented the following report which on motion regularly seconded and passed without dissent was adopted.

Your Reference Committee met and listened to the testimony of several doctors and after careful consideration unanimously approved the following resolutions:

Your Reference Committee recommends that the problem of whether modern osteopathy be classified as cultist healing be resolved as best it can by the Judicial Council of the American Medical Association.

Whereas, no school of osteopathy exists in Colorado there is no problem of whether doctors of medicine should teach in osteopathic schools. However, your Reference Committee recognizes the obligation of medicine as stated in the Code of Ethics to improve teaching wherever possible and feels that the answer to this question depends on the American Medical Association's answer to number one.

Whereas, relationship of doctors of medicine to doctors of osteopathy depends on whether osteopathy is defined as cultist healing or not, it is the

opinion of this committee that the answer to this question depends upon the American Medical Association's answer to number one.

At the request of AMA Delegate Halley the House on motion seconded and passed without dissent granted the AMA Delegates permission to present the above Reference Committee Report verbatim before the House of Delegates of the AMA.

Second Report of the Reference Committee on Constitution and By-Laws

Chairman Service of the Committee presented the following report which was adopted section by section and as a whole without dissent.

Your Reference Committee on Constitution and By-Laws recommends repeal of the Standing Rules of the House of Delegates creating the following committees because they are now provided for in the By-Laws as adopted at your last session:

1. Rocky Mountain Medical Conference Committee, as adopted September 22, 1937.

2. Colorado Interprofessional Council, as adopted September 8, 1938.

3. Public Health Committees as amended September 21, 1949.

Your Reference Committee recommends that in the Standing Rules pertaining to Reference Committees that the words "seven reference committees" in Line 4 be changed to read "six reference committees" in addition to any provided for in the By-Laws.

Your Reference Committee recommends that that portion of the Standing Rule pertaining to the reference committees creating a reference committee on Constitution and By-Laws be repealed.

Your Reference Committee recommends that the name of the Reference Committee on Public Relations be changed to read "The Reference Committee on Legislation and Public Relations" and that the last four words of the paragraph reading "and with medical economics" be deleted.

Your Reference Committee recommends that the name of the Reference Committee on Military Affairs and Miscellaneous Business be changed to Reference Committee on Miscellaneous Business and the paragraph be rewritten to read "To receive all reports not directly related to the reference committees previously named."

Your Reference Committee recommends the following Standing Rule: "The two immediate Past Presidents of the Colorado State Medical Society shall be invited to all deliberations of the Board of Trustees as ex-officio non-voting members, subject to the Constitution and By-Laws."

Third Report of the Reference Committee on Constitution and By-Laws

Chairman Service then presented the following separate supplemental report which was adopted without dissent.

Your Reference Committee has considered the Amendment to the By-Laws proposed by the Board of Councillors at Wednesday's Meeting of the House of Delegates. This Amendment adds sub-section C under Section 7 of Chapter XI of the revised By-

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Laws. We recommend the adoption of this Amendment, changing the word "suspend" to the word "postpone" in Line 8 of the proposed Amendment to the By-Laws.

The Speaker thereupon declared the By-Laws so amended*.

At the request of the Speaker, Secretary Sethman certified to the House that there was no business remaining on the desk. Speaker Beebe thereupon declared the House of Delegates adjourned without day.

The above abstract of Minutes is respectfully submitted to the Society.

HARVEY T. SETHMAN, Executive
Secretary, Secretary of the House
of Delegates.

*See Amendment Page 972.

Component Societies

EL PASO COUNTY

At the regular meeting of the El Paso County Medical Society held on Wednesday, November 11, 1953, at the VFW 101 Club with forty-one members and two applicants present, the following actions were reported:

Dr. Edward S. Maness and Dr. Joseph Pollard had the first reading of their applications for membership.

Reports of the El Paso delegates to the meeting of the Colorado State Medical Society in September were given.

Plans were announced for Diabetes Detection Week.

An invitation was extended to the officers of the State Society to meet with the El Paso County Medical Society in December.

Official Notice

Notice is hereby given to all members of The Colorado State Medical Society, as required by the By-Laws of the Society, that the following Rules and Regulations originally adopted August 21, 1931, revised in 1937, and re-revised in 1953, have been adopted by the Medicolegal Committee of the Society and have been approved by the Board of Trustees of the Society. This revision is to take effect January 1, 1954.

COLORADO STATE MEDICAL SOCIETY RULES AND REGULATIONS CONCERNING MALPRACTICE CLAIMS AND SUITS

Preamble: Under the provisions of Chapter VIII, Section 9, By-Laws of the Colorado State Medical Society, the following Rules and Regulations are hereby established to govern the Medicolegal Committee and all members of the Society, to become operative on January 1, 1954, as supplemental to and with the full force and effect of said Chapter VIII, Section 9, of the By-Laws.

Approved November 7, 1953; Board of Trustees, Colorado State Medical Society.

Rules and Regulations

I

No member of the Colorado State Medical Society shall be eligible to the aid of the Medicolegal Committee unless he has at all times conducted himself in strict compliance with the Constitution and By-Laws of the Society and more particularly Chapter VIII, Section 9, thereof, which reads in part as follows:

"Every claim or suit against any member of this Society, based upon alleged malpractice, shall, when called to the attention of the Committee, be thoroughly investigated in such manner and under such rules and regulations as may be prescribed by the Committee. All rules and regulations prescribed and adopted by the Committee may be amended by the Board of Trustees. The Medicolegal Committee shall prescribe and adopt rules for the investigation of claims or suits against members of the Society, and said rules, when approved or amended by the Board of Trustees, shall be published in the Official Journal of the Society, and shall be binding upon all members of the Society ten days after said publication. The Committee may designate the board of censors of, or may name referees in, any component society to act for the Committee in that society's jurisdiction, action of said board or referee to be subject to the final approval of the Committee. Neither this Society nor any Committee thereof may employ or furnish the services of any attorney or counsel, or pay any of the expenses thereof, in connection with any claim, suit or demand made or brought against any member of this Society as an individual, nor assume any liability for or pay any damages incurred by or awarded against any member of this Society."

II

Three members of the Medicolegal Committee shall constitute a quorum for all ordinary business of the Committee.

III

It shall be the duty of any member of the Society who is sued, or threatened with suit, for alleged malpractice to fill out at once and mail to the Executive Secretary of the Society a report of the case, on blanks provided for this purpose. Blanks are obtainable either from the Executive Secretary of the Society or from the secretary of any component society.

Failure to mail such a report within ten days after service of summons upon a member shall bar the member from assistance by the Medicolegal Committee.

IV

Should any member of the Society learn of a suit or threatened suit against any member of the medical profession, it shall be his duty forthwith to notify the Executive Secretary of the State Society, or the Chairman of the Medicolegal Committee.

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V

It shall be the duty of any member of the Society to appear before the Medicolegal Committee at any time when he may be called, and to give the Committee all information he may possess concerning the case in question.

VI

It shall be the duty of any member of the Society who contemplates assisting in the preparing or prosecution of a malpractice claim or suit, or testifying in any such proceeding, first to notify the Medicolegal Committee of his intention, giving his reasons therefor.

It shall be the policy of the Medicolegal Committee to act in all matters with due regard to the principle that the welfare of the patient is of first importance. It shall therefore be the privilege of every member of the Society to conduct himself in any malpractice proceeding as his conscience and judgment may dictate. The Medicolegal Committee holds solely that it must be informed in advance of the member's intended action.

VII

No member of the Society may speak disparagingly of the treatment given by any other member until he has made himself thoroughly familiar with all the circumstances as they existed at the time of the treatment. (Note Rule XIII.)

No member of the Society may make a charge for any services or accept any compensation for acting in regard to a malpractice claim or suit unless the Medicolegal Committee first gives its consent in writing.

VIII

No member of the Society may compromise or settle any malpractice claim or suit without the consent in writing of the Medicolegal Committee, except it be upon the advice and with the consent of his insurance carrier. The Medicolegal Committee must be immediately notified of the final disposition of the claim or suit.

IX

The Medicolegal Committee will not aid in the defense of any criminal action, nor in the defense of any other action if the Committee, after investigation, has reason to believe that a criminal act is involved or that the member being sued has not conformed to the recognized ethics of the profession.

X

The Medicolegal Committee will not aid in the defense of any malpractice claim or suit:

(a) If the member has at any time directly or indirectly contributed to a suit or threat of malpractice against a colleague by means of ill-advised and unjustified criticism.

(b) If the member has failed to keep accurate records of the pertinent details of the case in question.

(c) If the member has failed to have taken

x-ray pictures, and has failed to keep on file the originals, or accurate records or reproductions thereof, in all fracture cases and all injuries where fracture might reasonably be suspected; unless it can be shown that at the time and place it was impossible to obtain x-ray examination, or unless it can be shown in written records that the patient refused to have x-ray pictures taken.

XI

For the purpose of expediting the investigation of cases, the Medicolegal Committee may appoint any members of the Society to assist the Committee.

Unless and until others are specially appointed by the Medicolegal Committee for special reasons or in special cases, the Board of Censors of each component society of the Colorado State Medical Society shall promptly make local investigations and written recommendations to the Medicolegal Committee concerning each case.

XII

The decision of the Medicolegal Committee of the Colorado State Medical Society as to whether or not the Society shall support the defense of any member shall be final.

XIII

It shall be the duty of every member of the Society to bring to the attention of the Medicolegal Committee any violation of these Rules and Regulations, more particularly Rules VI, VII, and VIII; and it shall be the duty of the Medicolegal Committee to prefer charges against any member before the Board of Censors of his component society or the Board of Councilors of the Colorado State Medical Society if such member be deemed by the Committee to have violated any of the Rules and Regulations of the Committee.

Revision dated October 23, 1953.

By the Committee:

W. W. HAGGART, M.D., Chairman.
RUDOLPH W. ARNDT, M.D.
HAMILTON I. BARNARD, M.D.
C. SIDNEY BLUEMEL, M.D.
EDWARD J. MEISTER, M.D.
RALPH H. VERPLOEG, M.D.

Approved: November 7, 1953.

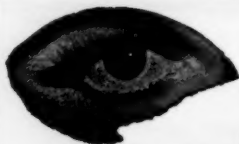
BOARD OF TRUSTEES of The Colorado State Medical Society;

I. E. HENDRYSON, M.D., Chairman.

Attest:

HARVEY T. SETHMAN,
Executive Secretary.

There is a "sensitive" period in the effective treatment of tuberculosis which applies not only to the tubercle bacillus, when it is most vulnerable to attack, but also to the patient when he is most receptive of advice. That period is when the disease is first discovered.—Eli H. Rubin, M.D., N. Y. S. J. of Med., June 15, 1953.



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MATERNAL and CHILD HEALTH

MANAGEMENT OF INGUINAL HERNIA IN PREMATURE INFANTS

ANDREW D. BULKLEY, M.D.
DENVER

In the Colorado General Hospital Premature Infant Nursery, attention was focused recently on the problem of inguinal herniae. Within the period of one week, one premature infant developed an incarcerated inguinal hernia and a second was brought to the emergency room three weeks after discharge from the nursery, with an incarcerated hernia (unrecognized by the mother). The former case is presented in detail.

CASE REPORT

A four-day-old, Spanish-American male infant, weighing 910 grams (two pounds) at birth, was transferred to the Colorado General Hospital Premature Infant Center on June 22, 1953. The prenatal history was noncontributory except for a spontaneous delivery at gestational age of 28½ weeks. Physical examination on admission revealed a small premature infant without significant abnormalities. The infant was started on q4h gavage feedings of 5 per cent glucose, converted to a half-skimmed milk formula on the third day. His hospital course was satisfactory for the following five weeks with a weight gain of 720 grams. On physical examination, July 31, discharged (age of 85 days) on an evaporated

milk formula, supplementary vitamins, and a hematinic. Discharge weight was 2,400 grams (5 pounds 4½ ounces).

of a grossly bloody stool confirmed the diagnosis of incarcerated hernia. An emergency left inguinal herniorrhaphy was performed under procaine and nitrous oxide anesthesia. Following surgery, oral fluid intake was supplemented with hypodermoclyses until normal bowel tones were audible (one day postoperatively). The infant made an uneventful recovery. He underwent an elective right inguinal herniorrhaphy eight days later without postoperative complications. Seventeen days after the first operation, the child was be patent. A decision was made to observe the infant for further evidence of herniation. On August 24, he began to regurgitate feedings, and on the following morning, examination revealed a tense, tender mass over the left inguinal canal which was felt to contain bowel. A partial reduction was effected manually and maintained with Trendelenberg positioning and ice packs. The infant was placed on clear liquids which were retained. However, eight hours later, the passage suspected bilateral undescended testicles with an associated right hydrocele. The presence of bilateral inguinal herniae could not be confirmed, although both inguinal canals were thought to masses were noted in both inguinal regions. Surgical consultation confirmed the presence of

REVIEW OF OTHER COLORADO GENERAL HOSPITAL CASES

Since June, 1950, congenital inguinal herniae have been diagnosed on fourteen premature infants (see table). Of these cases, one child weighed less than 1,000 grams; seven weighed between 1,000 and 1,500 grams, and six weighed between 1,500 and 2,000 grams. There were no cases found in the 2,000 to 2,500 gram weight group. In this series there were twelve males

Sex	Wt. Gms.	Pre-Op Diagnosis	Diagnosis	Age (days)	Operation
M	910	{ RIH	41	75	
		{ Strang LIH	41	56	
M	1077	RIH	76	83	
M	1250	RIH	58	60	
M	1276	RIH	50	?	
M	1347	{ Hydrocele	15		
		{ RIH	48	59	
M	1387	Incar RIH	71	71	
M	1488	RIH	35	66	
M	1538	RIH	30	?	
M	1588	LIH	?53	?	
M	1660	{ LIH	34	43	
		{ RIH	34	?	
F	1786	RIH	53	58	
F	1800	Mass in rt. labia (a)	75	?	

(a) Cystic ovary in right inguinal canal found at surgery.

RIH—Right inguinal hernia.

LIH—Left inguinal hernia.

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and two females. Admission examination revealed the presence of an hydrocele in only one instance but incomplete descent of the testicles was a common finding. Eight of the fourteen had an unilateral right inguinal hernia, and in five there were bilateral herniae. The majority of herniae when first seen were described as easily reducible, and in only three cases did incarceration or strangulation occur. In this series there were one set of twins, each of whom underwent herniorrhaphy, and two infants whose twin siblings have not developed evidence of congenital inguinal hernia to date. In two cases only, is there a history of hernia in the immediate family. Of the two female infants, one was found at surgery to have an incarcerated cystic ovary in the right inguinal canal; the other developed bilateral tender masses in the labiae which disappeared spontaneously. The incidence of post-operative complications in the series is small, there being one mild wound infection, one case of testicular swelling, and one case of post-operative melena.

Ranbar and Goldberg¹ in 1934 reported an incidence of inguinal hernia of 4.6 per cent for 779 infants weighing 2,500 grams or less. Excluding their small group of infants under 1,000 grams, with a high incidence of hernia and a low survival rate, they reported an approximately equal frequency in all weight groups. Ladd and Gross² reported that 60 per cent of congenital inguinal herniae confirmed at surgery were right-sided, 25 per cent were on the left, and 15 per cent were bilateral. This emphasizes the need to explore both inguinal regions, if the diagnosis of left unilateral hernia is made. In most cases seen at this hospital, symptomatology has not been striking. In early incarceration, however, it may

be more pronounced; with vomiting, anorexia, irritability, and constipation or diarrhea most commonly reported. Prior to the appearance of a mass, an inguinal canal defect can be diagnosed by gentle finger-massage over the canal. The classical confirmatory finding is described as a "silky" feeling under the palpating finger. In this series this maneuver apparently was not routinely employed, and consequently the diagnosis was never made prior to the onset of more obvious signs and symptoms.

In the management of inguinal hernias, the following suggestions are made on the basis of the experience at Colorado General Hospital:

1. An optimal time for elective surgery is considered to exist when the infant weighs over five pounds and appears vigorous.

2. Pre-operative transfusion with whole blood (10 cc/lb.) is recommended in the presence of anemia or to replace blood lost during surgery. Also low plasma protein levels are thereby supplemented to aid in wound healing.

3. Oral fluids are withheld four to six hours prior to surgery and, in uncomplicated herniorrhaphies, are started approximately four hours postoperatively. Although premature infants are prone to develop postoperative distention, this complication has not been prominent in our series.

4. An incubator or warmed bassinet will supply proper environment for temperature regulation. Supplementary oxygen³ is recommended postoperatively.

5. Antibiotics and/or chemotherapy are recom-

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mended. A subcuticular closure with a simple collodion dressing has proved satisfactory protection for the incision.

REFERENCES

- ¹Rambar, A. C., and Goldberg, S. L.: Pediatrics, 5:513:34.
- ²Gross, R. E.: The Surgery of Infancy and Childhood; Chap. 35. W. B. Saunders Co., Philadelphia and London, 1953.
- ³Gross, R. E., and Ferguson, C. C.: S. G. & O., 95:631:52.

Obituaries

HAROLD B. HENDERSON

Dr. Harold Henderson died September 24, 1953, at the Denver Presbyterian Hospital following a brief illness.

He was born November 8, 1888, at Montgomery, Pennsylvania. He attended Bucknell University and obtained his B.S. degree at Northwestern University in 1922, his M.D. degree in 1923. He started his practice in Denver in 1925, specializing in obstetrics and gynecology.

Dr. Henderson had served as chief of staff at Presbyterian Hospital. For fifteen years he was an assistant professor of obstetrics at the University of Colorado School of Medicine. He was a member of the American Medical Association, the American College of Surgeons, the Denver Gynecological and Obstetrical Society.

Dr. Henderson is survived by his wife, three daughters, a son and five grandchildren.

FLORENCE RENA SABIN

Colorado's famous Dr. Florence Sabin died suddenly at her home October 3, 1953, following a heart attack.

She was born November 9, 1871, in Central City, Colorado. She received her B.A. degree from Smith College after which she returned to Denver to teach at Miss Wolcott's School for two years. Later she entered Johns Hopkins Medical College from which she graduated with an M.D. in 1900.

Dr. Sabin enjoyed a long and illustrious career. She was the first woman to be appointed to the Johns Hopkins faculty, which appointment she received in 1902. In 1925 she was named to membership of the Rockefeller Institute for Medical Research, another first for a woman. She published numerous scientific papers in her field, the lymphatic system and the blood cell. In 1938, she retired from the Institute and returned to Denver with her sister.

Dr. Sabin, retired, was even busier than before. In 1944, she was named to the State Health Planning Commission, which group she headed from 1945 to 1947. Her work resulted in a complete revamping of Colorado's health laws. In 1947, she was named Denver's Manager of Health and Charity, which position she held for two years, donating her salary to research at Colorado General Hospital.

Dr. Sabin received many honors during her lifetime; she was elected to Honorary Membership by the Colorado State Medical Society in 1947 and by the Denver Medical Society to Honorary Membership in 1949.

She is survived by her sister, Miss Mary Sabin, a retired Denver high school teacher.

RICHARD B. WALDAPFEL

Dr. Richard Waldapfel of Grand Junction, Colorado, died at the Denver Presbyterian Hospital September 26, 1953, of carcinoma of the pancreas at the age of 50.

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GYNECOLOGY—Intensive Course, Two Weeks, starting February 15, 1954. Vaginal Approach to Pelvic Surgery, One Week, starting March 1, 1954.

OBSTETRICS—Intensive Course, Two Weeks, starting March 1, 1954.

MEDICINE—Electrocardiography and Heart Disease, Two Weeks, starting March 15, 1954. Gastroscopy, Two Weeks, starting March 8, 1954. Two-Week Intensive Course starting May 3, 1954.

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As a member of the famous Hajek Klinik of Vienna prior to the Hitler regime, Dr. Waldapfel was popular with American physicians who frequented his courses in laryngology and rhinology. He left Vienna in 1938 and settled in Grand Junction, where he practiced in the field of eye, ear, nose and throat.

Dr. Waldapfel eminently portrayed the complete man by his many humanitarian and cultural interests. His hobbies included painting, skiing, music, floral culture, photography, and the training of fine dogs. During the last two years of his life he studied art and produced outstanding paintings, both in oil and in water color. He was the recipient of the first prize in each class at the 1953 convention of the American Medical Association in New York City.

A keen student of his chosen field, Dr. Waldapfel contributed important clinical and research papers both in the German and English languages. He was frequently in demand as a lecturer before postgraduate groups in this country. Besides belonging to the A.M.A. and its local subsidiaries, Dr. Waldapfel was a member of the Colorado Otolaryngological Society, the American Academy of Ophthalmology and Otolaryngology, the Pacific Coast Oto-Ophthalmological Society, the American Society for Plastic Surgery, the Los Angeles Research Club, a fellow of the American College of Surgeons and a licentiate of the American Board of Otolaryngology.

Dr. Waldapfel is survived by his wife, Gretel, who this year is President of the Auxiliary of the Colorado State Medical Society.

Too much should not be expected from general population chest roentgenographic surveys. Certainly, many patients are diagnosed through surveys as having progressive disease. Placing them under medical supervision promptly may prolong or even save life. But "early diagnosis" is not synonymous with minimal disease and prevalence is far from synonymous with incidence. Analysis of the morbidity and mortality subsequent to original diagnosis is the test of the contribution mass chest roentgenographic surveys make to the tuberculosis case-finding program.—Wendell R. Ames, M.D., and Miller H. Schuck, M.D., *Am. Rev. Tuberc.*, July, 1953.

The mild, inapparent infection of early adolescent years may be the origin of the destructive tuberculosis of puberty or adulthood.—Rene J. Dubos, *Am. Rev. Tuberc.*, July, 1953.

MONTANA Medical Association

PROCEEDINGS OF THE HOUSE OF DELEGATES* MONTANA MEDICAL ASSOCIATION 75th ANNUAL MEETING September 19, 1953

The 75th Annual Meeting of the House of Delegates of the Montana Medical Association was called to order by James M. Flinn, M.D., President, Helena, at 9:20 a.m. in the Assembly Room of the Northern Hotel, Billings.

Following the roll call, Secretary Everett H. Lindstrom, M.D., Helena, announced that all delegates seated had presented proper credentials and that a quorum was present.

It was moved by B. C. Farrand, M.D., Jordan, that the reading of the minutes of the Interim Session of the House of Delegates held in Helena, March 13, 1953, be dispensed with, inasmuch as these minutes were published in the June, 1953, issue of the Rocky Mountain Medical Journal. This motion was seconded and carried. It was moved by B. C. Farrand, M.D., that the minutes of the Interim Session be approved as published. This motion was seconded and carried.

Raymond F. Peterson, M.D., Butte, delegate to the American Medical Association, reported at length upon the actions of the House of Delegates of the American Medical Association at its June meeting. This report was received and placed on file.

The Chairman of the Nominating Committee, J. M. Brooke, M.D., Ronan, presented the following report:

Your Nominating Committee respectfully submits the names of the following members

*These proceedings have been summarized. All motions and resolutions acted upon by the House have been included in these minutes but the Committee reports have been omitted. The reports of all Committees, however, are on file in the Executive Office of the Association, Stapleton Building, Billings, and a copy of any report will be furnished to any member upon request.



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of this Association as its nominees for the officers indicated:

President-elect: J. J. Malee, M.D., Anaconda; and E. S. Murphy, M.D., Missoula.

Vice President: George W. Setzer, M.D., Malta; and M. A. Gold, M.D., Butte.

Secretary-Treasurer: Wyman J. Roberts, M.D., Great Falls; and T. R. Vye, M.D., Billings.

Assistant Secretary-Treasurer: C. B. Craft, M.D., Bozeman; and Park W. Willis, Jr., M.D., Hamilton.

Executive Committee: James M. Flinn, M.D., Helena; and Frank L. McPhail, M.D., Great Falls.

President Flinn called for additional nominees from the floor, but none were presented. He announced that additional nominations would again be called for immediately preceding the election, which would be held at a subsequent meeting during this session.

The report of the Secretary-Treasurer, Everett H. Lindstrom, M.D., was received and placed on file.

The report of the Executive Committee was read by Secretary Lindstrom and placed on file. Following the presentation of this report, it was moved by Earl L. Hall, M.D., Great Falls, that the dates recommended by the Executive Committee for the 1954 Interim Session, March 5-6, be approved. This motion was seconded and carried. J. J. Malee, M.D., Anaconda, moved that the President be empowered to appoint a special committee on blood banks and one on veterans' affairs, as recommended by the Executive Committee. This motion was seconded and carried. It was moved by John A. Layne, M.D., Great Falls, that the resolution authorizing the President to appoint a special committee of this Association to act as a medical advisory committee and to cooperate with the Rocky Mountain Chapter of the Arthritis and Rheumatism Foundation to disseminate the latest information on arthritis and rheumatism, be approved. This motion was seconded and carried.

S. C. Pratt, M.D., Miles City, Chairman, presented the report of the Economic Committee, which was received and placed on file. It was moved by William A. Treat, M.D., Miles City, that the recommendation of the Economic Committee that the fee schedule of the Montana Physicians' Service be adopted as the schedule for medical services to indigent Indians when such services are paid for by the Bureau of Indian Affairs. This motion was seconded and carried. (This action was rescinded during the afternoon session and the average fee schedule

of this association temporarily established as the schedule of fees for medical services to such Indians.) J. A. Whittinghill, M.D., Billings, moved that the recommendation of the committee that the statements "Fee for Medical Services" and "Fee for Surgical Service" be added in an appropriate place on the standard insurance reporting form distributed by this Association. This motion was seconded and carried. It was moved by L. W. Brewer, M.D., Missoula, that the following resolution, proposed by the Economic Committee, be adopted by this House of Delegates:

Resolution

Whereas, Certain business groups are legally receiving taxation benefits in retirement pension insurance plans; and

Whereas, Physicians, as well as other self-employed individuals, are denied these benefits: Therefore be it

Resolved, That the House of Delegates of the Montana Medical Association go on record as approving the Jenkins-Keogh Bill.

This motion was seconded and carried. Herbert T. Caraway, M.D., Billings, moved that Mr. William G. Preston, as our insurance broker, be requested to investigate a retirement pension plan for physicians of Montana and that the Economic Committee submit a report upon the results of this investigation at the next meeting in March, 1954. This motion was seconded and carried.

The Chairman of the Necrology and History of Medicine Committee, L. W. Brewer, M.D., submitted the report of that Committee, which was received and placed on file. It was moved by John A. Layne, M.D., that an appropriation of \$100 be authorized for the expenses of the Committee in preparing its historical manuscript. This motion was seconded and carried.

President Flinn presented Frank E. Wilson, M.D., Director of the Washington Office of the American Medical Association. Doctor Wilson addressed the House of Delegates and reported upon the status of medical legislation in the United States Congress.

The House of Delegates recessed at 11:00 a.m.

The House of Delegates reconvened at 1:30 p.m. in the Assembly Room of the Northern Hotel, Billings.

The reports of the following standing and Special Committees of this Association were received and ordered placed on file after each was read by the chairman or committee member indicated:

Legal Affairs and Malpractice Committee—Park W. Willis, Jr., M.D., Hamilton.

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Cancer Committee—Raymond E. Benson, M.D., Billings.

Rheumatic Fever and Heart Committee—F. R. Schemm, M.D., Great Falls.

Program Committee—J. J. Malee, M.D.

Mediation Committee—F. S. Marks, M.D., Billings.

Maternal and Child Welfare Committee—Earl L. Hall, M.D.

Tuberculosis Committee—M. A. Gold, M.D., Butte.

Physicians-Schools Conference Committee—Everett H. Lindstrom, M.D.

Public Health Committee—S. C. Pratt, M.D.

The following representatives of this Association on other Committees or Councils presented the reports of their activities, which were received and placed on file:

State Committee for Student Affiliation in the Field of Public Health—L. S. McLean, M.D., Helena.

Montana Health Planning Council—Park W. Willis, Jr., M.D.

American Medical Education Foundation—Everett H. Lindstrom, M.D.

The report of the Public Relations Committee was presented by the Chairman, A. W. Axley, M.D., Havre. This report was received and placed on file. It was moved by Doctor Axley and seconded that the Mediation Committee of this Association be authorized to extend its investigative activities so that it may consider complaints from physicians as well as from patients. Park W. Willis, Jr., M.D., moved that this motion be amended by adding the words "in writing" after the word "complaints." This amendment was seconded and carried, after which the original motion was voted upon and carried.

President Flinn presented Larry Rember, Director of Field Service of the Public Relations Department of the American Medical Association, who extended the greetings of the General Secretary of the AMA, George F. Lull, M.D., and urged that all physicians in Montana support an active public relations program.

The report of the Legislative Committee was read by the Chairman, Park W. Willis, Jr., M.D., and ordered placed on file. It was moved by A. W. Axley, M.D., that the following resolution proposed by the Legislative Committee about the appointment of personnel of that Committee be adopted:

Resolution

Whereas, The Legislative Sessions are held in Helena biennially and the medical men of that area are convenient in location and accustomed to Legislative procedure; and

Whereas, The work of the Committee is more or less continuous from one Legislative Session to the next; Therefore be it

Resolved, That the Legislative Committee shall consist of seven members, including the Chairman. During the next administrative year, two members of the Committee shall be appointed for a one-year term, two for a two-year term, and two for a three-year term; thereafter all appointments shall be for a term of three years.

This motion was seconded and carried. It was moved by A. W. Axley, M.D., that the recommendation of the Legislative Committee that the President be authorized to appoint a special committee to review and recommend action upon the report of the Reference Committee of the House of Delegates of the American Medical Association on osteopathy be approved. This motion was seconded and carried.

The report of the Rural Health Committee, B. C. Farrand, M.D., Chairman, was received and placed on file. It was moved by D. S. MacKenzie, Jr., M.D., Havre, that the Rural Health

Committee be authorized to prepare and submit articles for publication in the Montana Farm Journal after such articles have been reviewed and edited by the Public Relations Committee and the Executive Committee of this Association. This motion was seconded and carried. A. W. Axley, M.D., moved that the House of Delegates authorize the Rural Health Committee to meet jointly each year with the Montana Public Health Association until such time as either Association revokes approval of the joint meeting. This motion was seconded and carried. J. J. Malee, M.D., moved that the House of Delegates authorize one member of the Rural Health Committee to attend the regional rural health conference in Denver during November, 1953, to represent this Association and that he be reimbursed for his travel and hotel expenses. This motion was seconded and carried. It was moved by John C. Hanley, M.D., Great Falls, that the House of Delegates authorize one member of the Rural Health Committee to attend the rural health conference sponsored by the American Medical Association to represent this Association and that he be reimbursed for his travel and hotel expenses. This motion was seconded and carried. It was moved by M. A. Gold, M.D., that the House of Delegates appropriate not more than \$150 to reimburse a speaker for his expenses at the joint meeting of this committee and the Montana Public Health Association during 1954. This motion was seconded and carried.

The report of the Hospital Relations Committee was received and placed on file following its presentation by Grant P. Raitt, M.D., Billings. It was moved by A. L. Vadheim, Jr., M.D., Bozeman, that this House authorize the Hospital Relations Committee to continue its evaluation program in clinical laboratory work and that an appropriation of not more than \$125 be authorized to finance this program during the coming administrative year. This motion was seconded and carried. It was moved by Earl L. Hall, M.D., that the House of Delegates authorize the Committee to continue its program of study and assistance to pathologists, radiologists, and anesthesiologists in their relations with hospitals. This motion was seconded and carried.

President Flinn requested C. F. Honeycutt, M.D., Missoula, Chairman of the Resolutions Committee, to report. Doctor Honeycutt read the following resolution urging voluntary contributions by physicians to the American Medical Education Foundation:

Resolution

Whereas, A resolution concerning the collection of a specified amount as a part of the dues to contribute to the American Medical Education Foundation, known as the Illinois Plan, was presented to the House of Delegates of the American Medical Association in June, 1953; and

Whereas, Action on this resolution was deferred pending consideration and action by the various state medical associations; and

Whereas, It is the consensus of opinion that it is inadvisable to further increase the dues of this Association for such a purpose; and

Whereas, The physicians of this Association realize their moral obligation to support their

alma mater and medical education in general through voluntary contributions; and

Whereas, Medical schools should be supported voluntarily rather than being financed through direct taxation: Therefore be it

Resolved, That the House of Delegates of the Montana Medical Association does hereby oppose this resolution; and be it

Resolved Further, That the House of Delegates of the Montana Medical Association does hereby encourage voluntary substantial contributions to this Foundation by our membership.

It was moved by L. W. Brewer, M.D., and seconded that this resolution be adopted. The motion carried. John A. Layne, M.D., Great Falls, J. J. McCabe, M.D., Helena, and H. W. Fuller, M.D., Great Falls, requested that their negative vote be recorded.

Doctor Honeycutt read the following resolution about retirement pension plans for self-employed individuals:

Resolution

Whereas, The citizens of the United States of America, practicing in the professions and certain others who are self-employed are interested in establishing voluntary retirement benefit plans of their own, unencumbered by federal taxation, as now accepted in industry; and

Whereas, The House of Representatives of the United States has been considering legislation known as the Jenkins-Keogh Bills; and

Whereas, These bills would enable professional people and certain others who are self-employed to so establish retirement benefit plans: Therefore be it

Resolved, That the House of Delegates of the Montana Medical Association urge the American Medical Association to continue to use every effort for the enactment of such legislation into law.

It was moved by C. H. Fredrickson, M.D., Missoula, and seconded that this motion be adopted. Motion carried.

The following resolution requesting the American Medical Association to revise its policy upon the payment of back dues was read by Doctor Honeycutt:

Resolution

Whereas, A resolution on the payment of back dues on behalf of the Minnesota State Medical Association was presented to the House of Delegates of the American Medical Association in June, 1953; and

Whereas, Action on this resolution was deferred pending consideration and action by the various state medical associations; and

Whereas, The Constitution and By-Laws of this Association require membership in the American Medical Association: Therefore be it

Resolved, That the House of Delegates of the Montana Medical Association request revision of the present policy of the American Medical Association for the payment of back dues as suggested by the Minnesota State Medical Association; to-wit, the payment of dues for such current year be sufficient for membership in good standing in the American Medical Association without the payment of back dues.

A. L. Vadheim, Jr., M.D., moved that this resolution be adopted. This motion was seconded and carried.

Doctor Honeycutt read the following resolution endorsing the objectives and purposes of the Association of American Physicians and Surgeons:

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Resolution

Whereas, In the political life of this nation efforts for socialization of all professional and business endeavor continues unabated in principle; and

Whereas, By change of method and definition of terms, these efforts have created in the minds of many people, including members of our own profession, a false sense of security that the trend toward socialization has been stopped; and

Whereas, The Association of American Physicians and Surgeons, since its inception, has proven to be a bulwark against the foes of free enterprise and is continuing the fight in our behalf; and

Whereas, The Montana Medical Association since 1946, has repeatedly supported and endorsed the activities of the Association of American Physicians and Surgeons; Therefore be it

Resolved, That the Montana Medical Association through its House of Delegates again recognize and register its approval and endorsement of the objectives and purposes of the Association of American Physicians and Surgeons and encourage all its members to maintain membership in A.A.P.S.; and be it

Resolved Further, That a copy of this resolution be sent to the national headquarters of A.A.P.S. and to the component societies of the Montana Medical Association.

It was moved by Park W. Willis, Jr., M. D., that this resolution be adopted. This motion was seconded and carried.

The following resolution expressing the appreciation of this Association to those individuals and organizations that contributed to the success of this 75th Anniversary Meeting was read by Doctor Honeycutt:

Resolution

Whereas, The spirit of hospitality and good fellowship extended to this House of Delegates and to all members of the Montana Medical Association by the Yellowstone Valley Medical Society and the City of Billings upon the occasion of our Diamond Jubilee Meeting is unsurpassed; and

Whereas, The Local Arrangements Committee of the Yellowstone Valley Medical Society and the Program Committee of this Association have so completely arranged for the conveniences and comforts to the House of Delegates and the entire membership of the Montana Medical Association; and

Whereas, The Eastern Montana College of Education has provided the facilities of the Science Building in which the scientific sessions have been held; and

Whereas, The management and staff of the Northern Hotel have provided superior service and facilities, which have contributed materially to the success of all functions, both social and administrative; and

Whereas, The Northwest Airlines Commissary has provided most attractive and appetizing luncheons during the clinical sessions; and

Whereas, Radio Station KOOK and the Billings Gazette have provided unexcelled press coverage of all important programs and transactions for the information of the public concerning the activities of our profession; Therefore be it

Resolved, That the House of Delegates of the Montana Medical Association does hereby express to the Yellowstone Valley Medical Society, the City of Billings, the Committee on Local Ar-

rangements and the Program Committee of the Association, the Eastern Montana College of Education, the Northwest Airlines, the Northern Hotel, the Billings Gazette and Radio Station KOOK of Billings, its most sincere appreciation; and be it

Resolved Further, That a copy of this resolution be sent to all the organizations that have aided in this well-planned and well-executed 75th Anniversary Meeting.

It was severally moved that this resolution be adopted. Motion seconded and carried unanimously.

Doctor Honeycutt read the following resolution expressing the appreciation of this House of Delegates to the Woman's Auxiliary to the Montana Medical Association and the Yellowstone Valley Medical Society:

Resolution

Whereas, The Woman's Auxiliary to the Montana Medical Association has always contributed greatly to the success of our annual meetings; and

Whereas, This 75th Annual Meeting of the Montana Medical Association, which is our Diamond Jubilee, has been eminently successful; and

Whereas, The members of the Woman's Auxiliary to the Yellowstone Valley Medical Society have contributed generously of their time, energy and talent; and

Whereas, Through their efforts exquisite decorations and entertainment were arranged at the annual banquet; and

Whereas, The members of the Auxiliary have given willingly of their time to assist in the registration of our members and guests; Therefore be it

Resolved, That this House of Delegates express to the officers and members of the Woman's Auxiliary to the Yellowstone Valley Medical Society and to the Woman's Auxiliary to the Montana Medical Association its sincere gratitude and appreciation for their efforts and interest which have contributed in great part to the success of this meeting.

It was severally moved and seconded that this resolution be adopted. Motion carried unanimously.

The following resolution conferring honorary membership upon M. A. Shillington, M.D., was presented by Doctor Honeycutt:

Resolution

Whereas, Maurice A. Shillington, M.D., has recently retired from the active practice of medicine in Montana and has moved to Minnesota; and

Whereas, Doctor Shillington has for many years been an outstanding member of the medical profession of the State of Montana; and

Whereas, Doctor Shillington has devoted a great portion of his time to the affairs of the Montana Medical Association; and

Whereas, Doctor Shillington has endeared himself to all of us; Therefore be it

Resolved, That the House of Delegates of the Montana Medical Association express to him its deepest appreciation for his long service in our behalf and that an Honorary Membership in the Montana Medical Association be conferred upon him.

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It was moved by L. W. Brewer, M.D., and seconded that this resolution be adopted and honorary membership conferred upon Doctor Shillington. This motion carried unanimously.

John A. Layne, M.D., reported that the Council of this Association at a joint meeting with the Executive Committee voted to request that the House of Delegates appropriate the sum of \$500 as the annual retainer for its legal counsel, Mr. E. G. Toomey, whom the Council again voted to employ for the coming calendar year. It was moved by Doctor Layne that the House of Delegates appropriate \$500 as recommended by the Council to employ legal counsel. The motion was seconded and carried.

George D. Waller, M.D., Cut Bank, suggested that the House of Delegates again discuss the proposal that the Montana Physicians' Service fee schedule be used in determining fees for medical services to indigent Indians. It was pointed out during the ensuing discussion that this Association last year had adopted an Average Fee Schedule and that this schedule should be the basis of any negotiation of fees for medical services with all agencies. It was moved by A. W. Axley, M.D., that the earlier action of this House of Delegates, proposing the M.P.S. schedule for medical services to Indians, be rescinded. This motion was seconded and carried. Doctor Axley moved that, until such time as the Economic Committee again reviews this question and submits further recommendations to the House of Delegates, the Average Fee Schedule published by this Association be approved as the schedule for medical services to indigent Indians when such services are paid by the Bureau of Indian Affairs. This motion was seconded and carried.

As there was no additional new business, President Flinn declared the election of officers the next order of business. He called for additional nominations for the offices of President-elect, Vice President, Secretary-Treasurer, Assistant Secretary-Treasurer and members of the Executive Committee.

E. S. Murphy, M.D., Missoula, one of the nominees for President-elect, requested that his candidacy be withdrawn.

It was then moved and seconded that the Secretary be instructed to cast a **unanimous ballot for J. J. Malee, M.D., for the office of President-elect.** This motion was carried.

F. D. Hurd, M.D., Great Falls, and T. W. Saam, M.D., Butte, were appointed by President Flinn to serve as tellers and were asked to distribute the ballots and tabulate the votes.

While the ballots were being tabulated by the tellers, James M. Flinn, M.D., presented the report of the President. Doctor Flinn expressed his thanks and gratitude for the honor of serv-

ing as President and his appreciation to all of the members of the Association for their cooperation. He reminded members of the House of Delegates of their responsibilities and suggested that each take an active interest in the affairs of this Association and the American Medical Association.

After the ballots were tabulated by the tellers, the results were presented to Everett H. Lindstrom, M.D., Secretary, who announced the election of the following to the office indicated:

Vice President—George W. Setzer, M.D., Malta.
Secretary-Treasurer—T. R. Vye, M.D., Billings.
Assistant Secretary-Treasurer—Park W. Willis, Jr., M.D., Hamilton.

Executive Committee—James M. Flinn, M.D., Helena; and Frank L. McPhail, M.D., Great Falls.

At the request of President Flinn, the incoming President, S. C. Pratt, M.D., was escorted to the rostrum. Doctor Pratt was then introduced to the assembled delegates and installed as President of this Association by Doctor Flinn.

Doctor Pratt in his address to the delegates expressed his appreciation for the honor that had been bestowed upon him. He urged that physicians work in close harmony with each other and with their colleagues in the allied fields so that the health professions would most rapidly attain their mutual goals of relative freedom from disease. He then read the following resolution commending Doctor Flinn for his administration as President of this Association:

Resolution

Whereas, James M. Flinn, M.D., has just completed a most distinguished term of office as President of the Montana Medical Association; and

Whereas, His inspired leadership and devoted service have led to the continued growth of this organization; and

Whereas, He has given unstintingly of his valuable time and great talents; Therefore be it

Resolved, That the Montana Medical Association express to him the deep appreciation of its members and extend to him its best wishes for many more years of the satisfaction which must come to him as a result of his unselfish and generous contributions in behalf of the medical profession.

It was severally moved and seconded that this resolution be adopted. Motion carried unanimously.

G. G. Sale, M.D., Missoula, moved that the retiring Secretary-Treasurer of the Association, Everett H. Lindstrom, M.D., be extended a rising vote of thanks for his invaluable service to the medical profession and to this Association during his several terms as Secretary-Treasurer. This motion was severally seconded and unanimously carried.

The newly-elected officers of this Association

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were then presented to the members of the House of Delegates and installed in their respective offices.

There being no further business, the meeting of the House of Delegates adjourned sine die at 5:00 p.m.

The following delegates, alternates and members of this Association attended the sessions of the House of Delegates:

Cascade County Medical Society: Wyman J. Roberts, Great Falls; F. D. Hurd, Great Falls; John A. Layne, Great Falls; H. V. Gibson, Great Falls; H. W. Fuller, Great Falls; John C. Hanley, Great Falls; Earl L. Hall, Great Falls; F. R. Schemm, Great Falls; and George W. Setzer, Malta.

Fergus County Medical Society: John W. Schubert, Lewistown; and Paul J. Gans, Lewistown.

Flathead County Medical Society: Walter G. Tanglin, Polson; and K. E. Bruns, Kalispell.

Gallatin County Medical Society: A. L. Vadheim, Jr., Bozeman.

Hill County Medical Society: A. W. Axley, Havre; and D. S. MacKenzie, Jr., Havre.

Lewis & Clark County Medical Society: Ray O. Lewis, Helena; James J. McCabe, Helena; S. A. Cooney, Helena; G. D. Carlyle Thompson, Helena; James M. Flinn, Helena; and Everett H. Lindstrom, Helena.

Mount Powell Medical Society: G. M. Donich, Anaconda; and J. J. Malee, Anaconda.

Northeastern Montana Medical Society: George D. Waller, Cut Bank; and S. D. Whetstone, Cut Bank.

Northeastern Montana Medical Society: David Gregory, Glasgow.

Park-Sweetgrass Medical Society: William E. Harris, Livingston.

Silver Bow County Medical Society: M. A. Gold, Butte; H. L. Casebeer, Butte; J. H. Brancamp, Butte; H. M. Clemmons, Butte; T. W. Saam, Butte; and C. S. Meeker, Butte.

Southeastern Montana Medical Society: J. R. Thompson, Miles City; S. C. Pratt, Miles City; William A. Treat, Miles City; B. C. Farrand, Jordan; J. S. Pennepacker, Sidney; M. D. Winter, Miles City; and M. G. Danskin, Billings.

Western Montana Medical Society: C. H. Fredrickson, Missoula; J. M. Brooke, Roman; Park W. Willis, Jr., Hamilton; L. W. Brewer, Missoula; W. F. Morrison, Missoula; A. R. Kintner, Missoula; G. G. Sale, Missoula; C. R. Svore, Missoula; and J. M. Nelson, Missoula.

Yellowstone Valley Medical Society: Elizabeth Grimm, Billings; J. A. Whittinghill, Billings; Walker Honaker, Billings; Grant P. Raitt, Billings; Paul J. Sullivan, Billings; G. B. Eusterman, Billings; R. E. Mattison, Billings; Herbert T. Caraway, Billings; T. R. Vye, Billings; B. K. Kilbourne, Hardin; D. N. Monserrate, Billings; Raymond E. Benson, Billings; L. C. Allard, Billings; Louis W. Allard, Billings; J. R. Soltero, Billings; and F. S. Marks, Billings.

UTAH

State Medical Association

Obituary

NIELS PETER PAULSEN

Dr. N. P. Paulsen of Logan, Utah, died October 9, 1953, after an extended illness.

He was born in Aarhus, Denmark, November 19, 1883, and came to this country at the age of six with his parents. They settled first in Minnesota and later came to Utah.

Dr. Paulsen attended the Utah State Agricultural College and then was graduated from the University of Chicago and Rush Medical College in 1907. His internships were served in Alexian Brothers Hospital and Chicago Lying-In Hospital in Chicago. He received his certificate in obstetrics from Dr. DeLee, internationally famous obstetrician of Chicago.

After serving internships in Chicago, Dr. Paulsen located in Portland, Oregon, where he was on the staffs of the Good Samaritan and St. Vincent's Hospitals.

In 1917, he entered the U. S. Army as a medical officer, spending five years in the regular army and four in the medical reserve.

Dr. Paulsen was a member of the American Medical Association, the Utah State Medical Association and the Cache Valley Medical Society.

He is survived by his widow; two sons, Dr. Gorgas R. Paulsen, Sturgeon Bay, Wisconsin, and Wallace L. Paulsen of Los Angeles, California.

Cooperative clinical research as applied to problems of tuberculosis therapy has been so eminently successful, regardless of the sponsoring agency, that other fields of clinical research should take more cognizance of this as a means to advance knowledge. While similar end results would eventually appear from more conventional studies, the time required to ascertain the truth would be greatly prolonged.—H. Corwin Hinshaw, M.D., Am. Rev. Tuberc., Aug., 1953.

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DR. GUY A. ASHBAUGH has retired as general practitioner in Weld. Dry town, surrounding community of three towns with total population of 1,200. His house and office are for rent for \$100 a month. For further information, call Frederick 2322, or write Box 9, Rocky Mountain Medical Journal, 835 Republic Building.

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Official Journal

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VOLUME L

January to December, 1953

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